MASSACHUSETTS
Money Follows the Person

Operational Protocol
Version 1.0

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Appendices

A. Project Introduction

1. Organization and Administration

Part #1: Systems Assessment and Gap Analysis

Describe the current long-term support delivery system in the State (include all populations – aged, MR/DD, MH, Physical disabled, TBI, and any other), progress to date, and "gaps" that will need to be addressed to "rebalance" the system. Focus on the system of long-term care service delivery, including the departments, agencies and providers (both community and institutional) that participate).

1.1 Current Long-Term Services and Supports (LTSS) System

Massachusetts has a comprehensive LTSS system that provides access to home and community-based services (HCBS) and facility-based care for many of the 630,000 individuals in Massachusetts with LTSS needs.[1] Massachusetts' LTSS policy is Community First, a policy that seeks to empower and support people with disabilities and elders to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based long-term supports that are person-centered, high in quality and provide optimal choice. In 2008, the Patrick Administration established the Community First Olmstead Plan, the framework for the Community First policy agenda and an action plan for the future of community-based LTSS in the commonwealth (see Appendix A).[2] The plan is the result of collaborative efforts between the administration, advocates in the elder and disability communities, providers, and consumers.

Community First includes a number of initiatives that promote the following four key objectives of the Money Follows the Person (MFP) Demonstration:

[1] 2007 American Community Survey (ACS), U.S. Census Bureau.

[2] The Olmstead Plan is the commonwealth's response to the U.S. Supreme Court ruling in *Olmstead v. L.C.*, which requires states to provide services to people with disabilities in the most integrated settings appropriate.

- Increase the use of HCBS, rather than institutional LTSS;
- Eliminate barriers that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary LTSS of their choice;
- Increase the ability of the state Medicaid program to assure continued provision of HCBS to eligible individuals who choose to transition from an institution to a community setting; and
- Ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services.

Massachusetts' LTSS rebalancing effort to date has resulted in a gradual shift in Medicaid (called MassHealth in Massachusetts) utilization and spending from facility- to community-based care.

An array of state agencies, departments and commissions provide HCBS and facility-based services to individuals with LTSS needs (see Table 1). The commonwealth funds these services through a combination of state and federal Medicaid dollars, state agency appropriations and other federal funding.

Table 1: Massachusetts State Agencies' LTSS Programs/Services	
Agency and Population(s)	**LTSS Programs/Services**
Executive Office of Elder Affairs – Aged	Case management, homemaker, supportive day care, adult day health, supportive home care aide, laundry service, personal emergency response, adaptive housing/equipment, companion, medication dispensing, personal care, home health services, home delivered meals, emergency shelter, transportation, grocery shopping/ delivery, chores, wanderer locator, vision rehabilitation, respite, habilitation therapy, behavioral health counseling, Frail Elder HCBS waiver
Department of Developmental Services – MR	Case management (service coordination), outreach and education, transportation, Turning 22 program, community residential, facility, individual, family, community day and employment supports, Adult Residential HCBS waiver, Adult Supports HCBS waiver, Community Living HCBS waiver, Autism HCBS waiver, Intermediate Care Facilities for the Mentally Retarded (ICF-MRs)
Department of Mental Health – MH	Case management, Program for Assertive Community Treatment (PACT), respite, Community-based flexible supports (with rehab option component), Clubhouse, non-acute inpatient hospital (including Institutions for Mental Disease (IMDs)), individual supports, Flexible supports (for kids), residential supports (for kids), recovery learning communities, community mental health centers/outpatient clinics (including emergency services), court clinics and jail diversion, homeless support services
Department of Public Health	Early intervention for children with a medical diagnosis that has a high probability of resulting in developmental delay; Public Health Hospitals
Mass. Commission for the Blind - Blind/Visually Impaired	Independent living social services including case management, orientation and mobility, rehabilitation services, specialized services for children, Turning 22 program, bridge program, vocational rehabilitation including assistive technology and employment supports.
Mass. Commission for the Deaf and Hard of Hearing - Deaf/Hearing Impaired	Case management, independent living services, communication access and training services
Mass. Rehabilitation Commission - Physically Disabled/TBI/ABI	Case management, independent living centers, Turning 22, assistive technology, MassAccess housing registry, supported living, head injury program, protective services, vocational rehabilitation, employment, Traumatic Brain Injury HCBS waiver, Acquired Brain Injury HCBS waivers
Office of Medicaid - MassHealth	State plan community-based and facility-based LTSS (see page 37), Senior Care Options (SCO), Program for All Inclusive Care for the Elderly (PACE), 1115 Demonstration waiver behavioral health diversionary services

MassHealth, which pays for the bulk of these services, covers a range of community-based and facility-based LTSS for its members through the Medicaid state plan and eight HCBS waiver programs. See page 37 for a list of services offered through the state plan and HCBS

waivers. These HCBS waiver programs serve frail elders, adults with intellectual disabilities, adults with brain injury, and children with autism. In FY 2009, 22,494 individuals were enrolled in the HCBS waiver programs, the majority of whom were either in the Frail Elder waiver (10,027 participants) or the DDS waiver (12,278 participants).[3,4]

In FY 2009, MassHealth spent $2 billion on community-based LTSS for 169,223 members (see Table 2). This includes both state plan and HCBS waiver spending. MassHealth spent $1.7 billion on facility-based care for 52, 371 members in FY 2009.

Table 2: MassHealth LTSS Spending[5]

Setting	Members			Expenditures		
	Elders (65+)	Disabled (<65)	Total	Elders (65+)	Disabled (<65)	Total
Community	58,532	110,691	169,223	$736 million	$1.235 billion	$2.001 billion
Facility-based*	41,941	10,430	52,371	$1.411 billion	$293 million	$1.704 billion
Total	***100,473***	***121,121***	***221,594***	***$2.147 billion***	***$1.558 million***	***$3.705 billion***

* Includes nursing facilities and inpatient rehab/chronic.

In addition to MassHealth spending, the state agencies listed in Table 1 spend close to $1 billion of discretionary state funds on LTSS for elders and adults and children with disabilities.

LTSS services are provided by an array of providers and care coordination organizations, including community mental health organizations, private home care and home health agencies, nursing facilities, chronic care hospitals, rehabilitation hospitals, hospice providers, and many more. Many of these providers, as well as consumers and advocates, have been involved in the development of most of the Community First Olmstead Plan initiatives over the past decade. A

[3] Data from MassHealth, November 2010.

[4] In FY 2009, the commonwealth operated only four waivers, including the Frail Elder waiver, the TBI waiver, a single DDS waiver, and the Autism waiver.

[5] Data from MassHealth, January 2011.

discussion of stakeholder involvement in the MFP Demonstration is included in Section B.4 (Stakeholder Involvement).

Recent legislative initiatives that advance the commonwealth's Community First policy include MGL, Chapter 211 of the Acts of 2006, which promotes choice of care setting for individuals determined by MassHealth to be clinically eligible for LTSS and created a LTSS options counseling program. MGL, Chapter 268 of the Acts of 2006 created the PCA Quality Home Care Workforce Council, which is charged with ensuring the quality of long-term, in-home personal care in the MassHealth Personal Care Attendant program. Since 2009, the commonwealth also expanded its HCBS waivers from four to eight, adding two new waivers serving individuals with acquired brain injury, and specific waivers to serve individuals with intellectual disabilities.

In order to further rebalance its LTSS system and advance the four key objectives of the MFP Demonstration, Massachusetts plans to implement additional reforms that may require legislative or regulatory changes. This includes the development of two new HCBS waivers to provide LTSS to individuals who do not currently qualify for one of the commonwealth's existing waivers. This effort is detailed in Section B.10 (Continuity of Care Post Demonstration). Additionally, the MFP Demonstration affords the commonwealth the opportunity to develop financial structures that support rebalancing, which may require future legal or regulatory changes.

1.2 Medicaid Programs and Services

A number of MassHealth programs and initiatives have advanced Massachusetts' efforts to rebalance state resources and ensure that elders and people with disabilities are served in the most appropriate setting for their needs. These efforts have resulted in facility-based spending

dropping from 56% of all MassHealth LTSS spending in FY 2005 to 46% in FY 2009.

MassHealth activities have expanded access to community-based state plan services to additional populations by eliminating barriers to their use (e.g., expanded use of family caregivers). Other initiatives have explicitly focused on diverting and/or transitioning individuals from facility-based settings (including hospitals, nursing facilities, ICFs/MR, and IMDs) to community-based settings. These initiatives include:

- ***CSSM:*** In 2005, MassHealth and the Executive Office of Elder Affairs implemented the Comprehensive Screening and Service Model (CSSM) initiative. This activity established interdisciplinary teams staffed by registered nurses and case managers, employed by Aging Services Access Points (ASAPs), to work with eligible MassHealth applicants and members of all ages residing in nursing facilities. The teams, which include the consumer and caregivers, develop a comprehensive community service plan to meet the needs of the consumer. Consumers also are monitored post-discharge to ensure that community service plans are effective and continue to meet their needs.
- ***ADRC:*** In Massachusetts, there are 11 regionally-based Aging & Disability Resource Consortia (ADRC) that are collaborations between ILCs and ASAPs. ADRCs provide a coordinated system of information and access to LTSS for individuals/family members regardless of age, disability or income. Since 2003, Massachusetts has been developing its ADRC model, improving consumer access to services through a "No Wrong Door" policy. This infrastructure is assisting the commonwealth to bridge elder and disability service systems.
- ***SCO:*** Initially implemented beginning in 2004, the Senior Care Options (SCO) program is now an option for more than 16,000 low-income elders who are dually eligible for

MassHealth and Medicare. SCO is a comprehensive, coordinated managed care plan that includes all services covered by Medicare and MassHealth (both state plan and HCBS waiver services), and an innovative model of geriatric care coordination. The commonwealth is in the process of developing a similar integrated care delivery model for non-elderly people with disabilities.

- ***Preadmission Screening Resident Review (PASRR):*** The Omnibus Reconciliation Act of 1987 requires that states operate a preadmission screening and resident review program. PASRR's intended purpose is to prevent the inappropriate admission or continued stay in nursing facilities of persons with serious mental illness (SMI), mental retardation (MR) or other developmental disability (DD) and to ensure that all nursing facility applicants and residents, regardless of payer source, are identified, evaluated and determined to be appropriate for admission or continued stay and provided with specialized services (SS), if needed. State entities leverage this screening activity to identify individuals whose care can best be managed in community settings. For instance, as part of the Department of Developmental Service's (DDS), the commonwealth's mental retardation authority, PASRR Level II review process, DDS identifies nursing facility applicants or residents who are affected by MR or DD. For certain individuals identified through this process who can benefit from community services, DDS then arranges comprehensive case management, creates transition plans and provides transition services to individuals. These activities result in the diversion and transition of individuals from institutions.
- ***State Facility Closure Initiatives:*** Both the state's Department of Developmental Services and Department of Mental Health have implemented plans to reduce facility bed capacity. These facility closure plans as well as prior de-institutionalization initiatives have enabled

these state agencies to create specialized teams to support individuals in transitioning to state and Medicaid funded state plan and HCBS waiver services. These initiatives have enabled state agencies to shift funds previously used for facility beds to community-based services.

Although these initiatives have greatly expanded access to HCBS and resulted in an increase in utilization of and spending on HCBS, there are still areas where the commonwealth can improve access and expand services for people with LTSS needs.

Currently, there is uneven access to the comprehensive community-based LTSS offered through HCBS waivers depending on an individual's diagnosis, age or income status. As noted earlier, only four populations are eligible for the commonwealth's existing HCBS waivers: frail elders, adults with intellectual disabilities, adults with brain injury and children with autism. Additionally, adults with serious and persistent mental illness can access a broad array of HCBS through MassHealth and state-funded programs. However, individuals who have developmental/intellectual disabilities but who do not have mental retardation and those with adult onset diseases or disabilities (such as multiple sclerosis) have less access to HCBS.

Through the demonstration, the commonwealth seeks to expand the services and supports that are available to individuals with LTSS needs. These include cueing/monitoring and homemaker supports (including meals preparation) for people with cognitive or psychiatric disabilities or brain injuries, developmental disabilities, and mental illness; funded peer supports and respite services for people with physical and/or psychiatric disabilities; and self-direction/individual budget opportunities for individuals other than those enrolled in a DD waiver.

The commonwealth would like to increase access to HCBS, by:

- strengthening functions and services to support those who wish to transition out of facilities,

- creating broader and comprehensive information about and access to transitional assistance,
- promoting availability and utilization of state plan services for those transitioning, and
- developing two new HCBS waiver programs for people with disabilities not currently eligible for one of the existing waiver programs.

The commonwealth's MFP Demonstration would be a fundamental component of a broader effort in the state to transform its health care system. This broader effort includes initiatives to integrate care delivery and Medicaid and Medicare financing for dual eligibles under age 65, expand the development of ADRCs, encourage primary care practices to evolve into patient-centered medical homes, and expand care coordination opportunities, through complex care management and the creation of health homes, for individuals with chronic conditions. Many of these initiatives are supported by opportunities in the Patient Protection and Affordable Care Act (ACA). Together, these activities will expand access to community-based services and care settings for elders and people with disabilities, promote efficiency in health care delivery and provider reimbursement, and improve quality of care and patient outcomes.

1.3 Populations/Potential Participants in the MFP Demonstration

MassHealth has analyzed the number of people it expects to participate in the MFP Demonstration. The commonwealth estimates that there will be 2,192 total MFP participants through CY 2016, of which 1,490 will be transitioning from nursing facilities.

Projected MFP Participants	CY11	CY12	CY13	CY14	CY15	CY16
MFP Participants Each Year	179	443	451	373	373	373
Cumulative MFP Participants	179	622	1,073	1,446	1,819	2,192

1.4 Self Direction

Massachusetts has a long history of providing self-directed LTSS. In the 1970s, MassHealth implemented the Personal Care Attendant program, which allows

MassHealth members to hire, and supervise, and fire their own personal care attendants. Since then, both MassHealth and the state agencies that offer LTSS have gradually expanded individuals' choices in directing their own LTSS. This includes the elder Home Care Program, many services in the DDS adult waivers and all of those services offered through the Autism waiver. A complete description of Massachusetts' self-direction activities under the MFP Demonstration can be found in Section B.7 (Self-Direction).

1.5 Stakeholder Involvement

Massachusetts has actively engaged stakeholders in the development of its Community First initiatives, including the Real Choice Systems Change grant, which created a model of collaboration between state agency staff and consumers. The Systems Transformation grant built upon this relationship by including providers in the on-going conversation, and collaboratively created products such as the Community First Olmstead Plan (2008), the Consumer Involvement Toolkit (2010), and the Standing Olmstead Advisory Committee (2010). The commonwealth also collaborates with consumers, providers and other stakeholders through its MassHealth Medical Care Advisory Committee, monthly MassHealth Advocates meeting, and Dual Eligibles Initiative Stakeholder meeting.

The implementation and operation of the MFP Demonstration will continue to involve stakeholders through the Standing Olmstead Advisory Committee's MFP Working Group and various online opportunities for input. The MFP Working Group collaborated with and advised the commonwealth as it developed its MFP Demonstration application. For a more detailed discussion of the MFP Working Group and how stakeholders will be involved in the Demonstration, please see Section B.4 (Stakeholder Involvement).

Part #2: Description of the Demonstration's Administrative Structure

Describe the Administrative structure that will oversee the Demonstration, including the oversight of the Medicaid Director, which agency will be lead agency, all departments/services that will partner together, administrative support agencies that will provide data and finance support, and what formal linkages will be made and by what method (e.g., Memorandum of Agreement, reorganization).

The Massachusetts Executive Office of Health and Human Services (EOHHS), under the leadership of Secretary Judy Ann Bigby, MD is the single state agency for the Medicaid program. As EOHHS Secretary, Dr. Bigby directly oversees the multiple human services agencies that will be involved with planning, collaborating on, and implementing the MFP demonstration. The organizational chart (see pg. 80) represents the administrative structure of the agencies and offices that will partner together to make the MFP Demonstration a success. The MFP Demonstration will benefit from the direct and ongoing involvement of staff and programs across EOHHS as described below.

Oversight of the MFP Demonstration by the Medicaid Director, Terry Dougherty, will be assured through the direct designation of two members of the MassHealth Executive Team who will report directly to the Medicaid Director on all aspects of the Demonstration: the Director of Member Policy and Program Development and the Director of the Office of Long Term Care. The MFP Project Director will lead an MFP Project Unit housed in the Office of Medicaid (the administrative office of the MassHealth program) and will report directly to the Director of Member Policy and Program Development. Here, responsibility will reside for all MFP-specific administration, program development and implementation activities. The MFP Project Director will establish many essential connections within the Office of Medicaid/MassHealth to advance the Demonstration and ensure compliance with all CMS requirements. Key connections will include those to the: Director of Federal Financing; MassHealth Chief Financial Officer; Director

of Community Based Waivers; Legal Unit; Compliance/Program Integrity Unit; Chief Operations Officer; Office of Long Term Care; Office of Behavioral Health; Office of Acute and Ambulatory Care; MassHealth Quality Office; Federal Reporting Unit; and IT development units. This structure will ensure that the MFP Demonstration is fully incorporated in the Medicaid agency's mission and infrastructure and that the MFP Project Director has access to all supporting resources under the direction of the Medicaid Director.

The MFP Project Unit will be resourced with these additional full-time MFP hires: Assistant Project Director; MFP Housing Coordinator; Financial Analyst; Waiver Liaison and an administrative assistant. The MFP Project Director will oversee procurement of 5 Regional Housing Coordinators as well as the contracting of entities that will provide specific expertise and staffing to enhance transition activities throughout the state.

The Director of the Office of Long-Term Care will provide expertise, resources and access to both Executive Office of Elder Affairs and MassHealth long-term care support systems. These include: SCO; PACE; Frail Elder Waiver; various contractual relationships with entities providing direct services to elders and people with disabilities in need of LTSS; interface with key MassHealth LTC providers, including Nursing Facilities, Chronic and Rehabilitation hospitals, DME providers, PCM agencies and fiscal intermediaries, Adult Foster Care providers; and a wide range of State Plan community support services that will be critical to MFP participants.

The EOHHS Assistant Secretary for Disability Policy and Programs, along with the Medicaid Director, will help provide strategic direction and alignment with the Governor's and Secretary's policy objectives, specifically the advancement of the Community First policy. The Assistant Secretary will promote stakeholder engagement, inter- and intra- secretariat

relationships, especially coordination between the MFP Demonstration and the EOHHS agencies serving people with disabilities.

The Massachusetts Rehabilitation Commission (MRC) currently operates 3 HCBS waivers for people with brain injury. These waivers will provide community supports to certain MFP participants during and after their demonstration eligibility. Additionally, MassHealth will establish an Interagency Service Agreement (ISA) with MRC to support critical components of the MFP Demonstration including operational oversight of 2 new MFP HCBS Waivers to serve participants after their transition from qualified institutions to the community. These new waivers will be available to residents of facilities regardless of diagnosis or age and are necessary to address the needs of populations that may not now have a primary agency of tie or may not be in target populations of existing Waivers. MRC will also provide oversight for 365 days of case management of State Plan services to MFP Demonstration participants who do not have the need for, or do not want to enroll in an HCBS Waiver after transitioning back to the community. MRC will be a primary partner in developing residential habilitation options and assistive technology solutions for MFP participants and has strong linkages with ILCs and the Aging and Disability Resource Consortia.

The Department of Developmental Services (DDS) will be another important partner in MFP development and implementation. DDS currently operates 3 HCBS Waivers for people with intellectual disabilities. These waivers will provide community supports to certain MFP participants during and after their demonstration eligibility. As the primary agency of tie for people with intellectual disabilities, DDS will play a key role in identifying MFP participants, supporting transitions from ICF/MRs, providing case management and home and community based services. DDS will offer the MFP project valuable experience as we develop self-direction

options and processes for a wider group of MassHealth members. Community options made possible through MFP will support the closing of the ICF/MR beds and facilities and the successful community placements for those residents will be in the first order of priority for the Demonstration.

The Executive Office of Elder Affairs (EOEA) is another key partner with MassHealth in providing oversight and direction to the MFP Demonstration. EOEA is the primary agency of tie for Massachusetts elders. EOEA has critical contractual relationships with ASAPs as well as expertise in providing services and assessing the needs of elders, who comprise the largest segment of facility residents. There is a wide array of programs managed by EOEA that will intersect with the MFP Demonstration. Most notably, SCO, PACE, and the Frail Elder Waiver are 3 primary delivery options available to MFP participants who are elders as they reenter the community. Through the link to ASAPs, EOEA, similar to MRC, plays a major role in the support and promotion of Aging and Disability Resource Consortia.

The Department of Mental Health (DMH) will offer significant input, guidance and expertise in developing necessary supports and services for MFP participants who have mental health/behavioral health issues that impact their ability to live in the community. The development of appropriate and effective community-based supports for MassHealth members with behavioral health issues living in facilities is particularly exciting, as this is frequently a barrier to discharge for individuals associated with DMH, for elders and brain injured/cognitively compromised persons in nursing facilities, and other individuals with disabilities in inpatient settings. The MFP Demonstration will count on DMH to strengthen connections to community-based programs and agencies that focus on the abilities of people with mental health challenges to live successfully in the community accessing peer support, recovery-

focused programs, and an array of home and community based services.

Other critical EOHHS partnerships will be with: the Department of Public Health, Massachusetts Commission for the Blind; and the Massachusetts Commission for the Deaf and Hard of Hearing.

Outside of EOHHS, the primary agency partnership will need to be with the Department of Housing and Community Development (DHCD) in the Executive Office of Housing and Economic Development. The lack of affordable housing options will be a formidable barrier to community reentry for MFP participants even with the availability of needed support services. One of the most challenging aspects of the MFP Demonstration is the very expensive and tight housing market that exists in Massachusetts. To this end, a key component of the demonstration will be to enhance strategies to facilitate greater cooperation with DHCD to track and, where possible, expedite subsidy applications, identify subsidized housing vacancies and identify MFP participants to the housing entities to achieve recognition by them of the needs and readiness of MFP participants to live in the community.

Communications for planning, project management and implementation activities will be done through a number of workgroups, standing management meetings and stakeholder forums. The following formal linkages will be the foundation for strategic direction, information exchange and support throughout the MFP demonstration:

- The Secretary of Health and Human Services convenes a monthly Leadership meeting that includes the heads of every EOHHS agency.
- The Medicaid Director convenes weekly MassHealth Executive Team meeting of all managers reporting to Medicaid Director where MassHealth development projects are discussed.

- An MFP Executive Team has been created which will be the direct decision-making apparatus for MFP implementation.
- An MFP Core Group has been created with representatives from each EOHHS partner agency which is a working group for all deliverables of the project.
- The Standing Olmstead Committee, MFP Working Group has been meeting throughout the initial planning efforts for the MFP grant proposal. This group will continue to be a primary source for stakeholder input on-going throughout the demonstration.

2. Benchmarks

Provide a list of proposed annual benchmarks that establish empirical measures to assess the State's progress in transitioning individuals to the community and rebalancing its LTSS system. Two specific benchmarks are required by all awardees (see below). In addition, awardees must propose, at a minimum, three additional measurable benchmarks which address elements of rebalancing.

Each year of the demonstration, the commonwealth will report on its progress in transitioning individuals to the community and rebalancing its long-term care system. CMS requires each proposed measure to include annual targets that are measurable, achievable, and realistic.

Required Benchmarks

Benchmark 1: Meet the projected number of eligible individuals transitioned in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.

Measure: Number of unduplicated participants projected to transition in each target group during each calendar year compared to actual number of unduplicated participants projected to transition in each target group during each calendar year.

Actual Transitions - All Projected	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	Total Count
Elderly	101	229	257	257	257	257	1,358
MR/DD	26	71	45	0	0	0	142
Physically Disabled	51	122	109	76	76	76	510
Mental Illness	1	21	40	40	40	40	182
Total per CY	**179**	**443**	**451**	**373**	**373**	**373**	**2,192**

Benchmark 2: Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.

Measure: State Medicaid HCBS expenditures during each calendar year of MFP Demo compared to prior calendar year's State Medicaid HCBS expenditures.

In the context of MFP, State Medicaid HCBS expenditures are those waiver, Demonstration, and State Plan services for which the State will seek an enhanced match under MFP. The table contains the projected costs of these services for all individuals in the given year. The projected annual increase in total HCBS funding is based on historical data for each HCBS service category trended forward with an increase in waiver spending growth based on MFP transitions.

State Medicaid HCBS Expenditures ($M)	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Benchmark and Projected MOE during MFP Demo	*$2,587*	*$2,971*	*$3,297*	*$3,639*	*$3,998*	*$4,417*	*$2,432*

Massachusetts' Additional Benchmarks

Benchmark 3: Massachusetts will close 3 ICFMR facilities during the Demonstration.

Measure: Number of ICFMR facilities closed between January 2011 and September 30, 2016.

Number of ICFMRs	CY2011 - CY2016
Massachusetts ICFMRs Closed	3

Benchmark 4: At least 30% of MFP participants (calculate #s based on MFP projections) have the option to self-direct a service in their care plan.

Measure: # of MFP participants each year that have at least one service that may be self-directed in the list of services that they have access to/# of MFP participants each year.

MFP Participants	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
MFP Demonstration Participants	179	443	451	373	373	373
Benchmark Target	30%	30%	30%	30%	30%	30%
Calculated MFP Participant Target	**54**	**133**	**135**	**112**	**112**	**112**

Benchmark 5: At least 75% of MFP participants (calculate #s based on MFP projections) indicated that those who receive help are treated by their helpers the way they want them to (Question 22) during the 11 month or 24 month MFP Quality of Life Survey.

Measure: (1) Number of MFP participants who indicated "Yes" on Question 22 during the 11 month or 24 month survey divided by (2) the number of individuals that answered "Yes" plus the number of individuals that answered "No." Note that the projected number of surveys includes responses from the projected 5% of surveys at each of the 11-month and 24-month interviews that Massachusetts expects may need to be repeated.

MFP Participants	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
MFP QoL 11-month and 24-month Surveys	0	186	482	772	870	788
Benchmark Target	75%	75%	75%	75%	75%	75%
Calculated MFP Participant Target	**0**	**140**	**362**	**579**	**653**	**591**

B. Demonstration Implementation Policies and Procedures

1. Participant Recruitment and Enrollment

Describe the target population(s) that will be transitioned, and the recruitment strategies and processes that will be implemented. Specifically address the issues listed below. The draft OP may include sample recruitment/enrollment materials that will be disseminated to enrollees if developed. Your OP may include materials developed as appendices after the grant award is made and before the final approval of the OP.

The MFP Demonstration will further the commonwealth's transformation of its system by building on current efforts and infrastructures that currently support the transition of individuals from nursing facilities and state operated facilities. These efforts will be expanded and the MFP Demonstration will include:

- Adults and elders residing in nursing facilities and chronic and rehabilitation hospitals;
- Adults with developmental disabilities residing in nursing facilities and chronic and rehabilitation hospitals;
- Adults with adult onset disabilities residing in nursing facilities and chronic and rehabilitation hospitals;
- Adults with developmental disabilities residing in ICF/MRs; and
- Individuals over 65 and under 21 with mental illness residing in IMDs;
- Adults with mental illness residing in nursing facilities or chronic or rehabilitation hospitals.

All adults who meet the definition of an MFP "eligible individual" will be targeted for recruitment and enrollment in the MFP Demonstration. The commonwealth will not target specific subgroups of adults or specific geographic areas, allowing for diversity of the population served and statewide coverage.

Participant recruitment and enrollment strategies for the MFP Demonstration will mirror those the commonwealth recently created for its ABI and DDS HCBS waivers, including community meetings, outreach in specific facilities, and the use of brochures (see Appendix B). Prior to the implementation of outreach activities, the commonwealth will send a letter to all qualified institutions to announce the MFP Demonstration, its goals and objectives,

and the methods of communicating with facility residents. The letter will require that facilities allow resources performing outreach to have access to residents in order to offer information about community-based living options. The letter will include assurances of the privacy of the residents' personal information and that no resident will be compelled or coerced to participate in any discussion or effort to transition to the community.

The MFP Working Group (described in Section B.4, Stakeholder Involvement) will have the opportunity to review the letter and to assist in disseminating information throughout the commonwealth. For more information on specific MFP outreach and education mechanisms and materials, see Section B.3 (Outreach/Marketing/Education). The commonwealth will provide MFP-specific materials prior to finalization of the commonwealth's operational protocol.

a. How Service Providers Will be Selected

In the first year of its MFP Demonstration, the commonwealth primarily will build on existing systems for the administration and delivery of transition supports. State agency staff and contracted ASAP staff currently perform these administrative functions for individuals residing in IMDs, ICF/MRs and nursing facilities. These resources will coordinate transitions for consumers entering the HCBS waivers that will be leveraged to provide community supports to Demonstration participants. ILCs are critical resources within the commonwealth's community service capacity, bringing their independent living expertise to supporting individuals with disabilities. Massachusetts also will enhance its current transition coordination efforts by competitively procuring specialized transition coordination expertise. Resources for this contracted work are part of the MFP Demonstration administrative budget.

The commonwealth will issue a request for proposals that will detail the requirements of the contracted entities and ensure that the commonwealth has sufficient independent

living, behavioral health, and disability expertise to support and enhance existing transition teams and capacity. The commonwealth will require that all transition entities are partners within our ADRC infrastructure.

b. Participant Selection Mechanism

MFP Demonstration participants will be identified through a variety of mechanisms, and include individuals 18 years of age or older. Individuals residing in ICF/MRs, IMDs and in nursing facilities will be able to enroll in the MFP demonstration if their unmet needs can be addressed through the MFP demonstration services, the Medicaid state plan and/or available HCBS waiver options. The entities that will provide community based case management to these individuals will be responsible for ensuring that individuals meet the following MFP demonstration selection criteria: resides (and has resided for a period of not less than 90 consecutive days, excluding rehab days) in an inpatient facility (qualified institution), is receiving Medicaid benefits for inpatient services, and is Medicaid eligible at least the day prior to discharge. Similarly, individuals residing in chronic and rehabilitation hospitals, including Department of Public Health facilities, who are identified through discharge planning and outreach efforts will be enrolled in the MFP demonstration.

The commonwealth seeks to build on the current collaboration that exists between nursing facilities and community based providers by leveraging information made available through the Minimum Data Set 3.0.

Entities involved in the identification of MFP participants will be trained on the MFP Demonstration services, benefits and infrastructure. These entities will provide information on available community supports to MFP participants and assist them to develop plans that address their unmet community support needs.

c. Qualified Institutional Settings

All Medicaid-licensed nursing facilities (NFs), institutions for mental disease (IMDs), chronic and rehabilitation hospitals, and intermediate care facilities for the mentally retarded (ICF/MR) in the commonwealth will be included in the demonstration, regardless of geographic location. Outreach activities will target all eligible individuals who reside in these settings. All Medicaid-licensed NFs meet the statutory definition of a qualified institution (section 6071(b)(3), "inpatient facility", of the Deficit Reduction Act of 2005). All Medicaid-licensed ICF/MR, institutions for mental disease (IMDs), and chronic and rehabilitation hospitals also meet the statutory definition of a qualified institution.

d. Minimum Residency Requirements

Massachusetts will assure that only Massachusetts Medicaid eligible residents participate in the MFP Demonstration and are MFP-qualified consistent with the requirements of the Patient Protection and Affordable Care Act of 2010 (ACA) and the MFP Demonstration solicitation and MFP technical assistance sessions. Transition coordination entities and state agency staff will be responsible for determining that an individual meets the MFP-qualified criteria, including length of stay requirements, and in documenting that determination. The MFP Project Director will be responsible for implementing a quality control process to ensure the accuracy of the information and in addressing any issues identified.

e. Medicaid Eligibility at least The Day Prior to Transition

Transition coordination entities and state agency staff will be responsible for determining that an individual meets the MFP-qualified criteria, including confirming that the individual is eligible for Medicaid at least the day prior to transition, and for documenting that determination.

The MFP Project Director will be responsible for implementing a quality control process to ensure the accuracy of the information and in addressing any issues identified.

f. Level of Care/Readiness to Transition

As stated above, transition coordination entities and state agency staff will be responsible for determining that an individual meets the MFP-qualified criteria, including length of stay requirements, and for documenting that determination. Once an MFP-qualified person is identified, transition coordination will include working with the potential participant and his/her discharge team in the institution, through a person-centered process that will assess community living needs, consider individual's readiness to transition into the community, and identify the HCBS necessary to support the individual's transition and continued tenure in the community.

g. Reenrollment and Reinstitutionalization Policies

Individuals seeking to return to the community through the MFP process will be eligible for transition services for up to six consecutive months while they remain in the facility-based setting. An individual can successfully transition to the community and into MFP LTSS based on use of the transition services, and then re-enter a facility due to another event. As such, the commonwealth proposes that individuals who return to the community but are then admitted to a facility, prior to completing 365 days in the community, will maintain their MFP eligibility, but will be suspended from the demo for the period of their facility stay up to 90 days. Once such individuals are discharged from inpatient care, they will resume their status as MFP participants and be eligible to receive MFP services for any remaining days up to the maximum 365 days of demonstration participation. For administrative purposes, an MFP participant will be considered disenrolled after an inpatient stay of more than 90 days. However, upon discharge, such

individual's MFP participation will resume for the remainder of their 365 day period, without a requirement to reestablish a 90 day period excluding rehabilitative days.

h. Ensuring Informed Choices about Supports and Services

   i. Training/information to participants

   ii. Entities responsible for providing training/information and frequency of training/education

Case managers follow standard procedures and time frames in performing the intake, assessment, case conferencing and service planning and review process that ensure a participant's needs, risk factors and personal goals are identified and appropriately addressed. Through the person-centered planning process, the case manager facilitates the development of the service plan with the participant. The case manager explains programs and services to the participant, guardian and other involved family members, and assists him or her in identifying individuals to participate in his/her person-centered plan development team and in selecting from an array of available services including waiver services, Medicaid state plan services and other supports, both formal and informal, which address the participant's needs and expressed goals.

Upon enrollment into the MFP Demonstration program all participants will receive educational materials from their case manager. The informational material describes what abuse, neglect and exploitation are; who is protected; who must report it; how to report it and what happens after a report is made. Every participant is provided with the state's 24 hour/ 7 day a week hotline number to report abuse, neglect, and exploitation. The case manager also has a responsibility to verbally reinforce written materials given to participants and to accommodate provision of information in an accessible format.

In addition to the materials provided by the case manager all service providers are required, as part of their core responsibility, to inform all participants of their right to be free from abuse and neglect, as well as the appropriate agency to whom they should report allegations of abuse, neglect or exploitation. Participants and their families are given the information both verbally and in writing.

MFP participants will receive educational materials regarding abuse and neglect upon enrollment. Case managers will review this material with participants during care planning meetings. Service providers will provide educational materials to participants at the initiation of services.

The Massachusetts Disabled Persons Protection Commission and Elder Protective Services provide on-going education to disabled adults, elders, family members and others as appropriate through a variety of media.

2. Informed Consent and Guardianship

a. Informed Consent Procedures

Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.

Informed Consent Process

Massachusetts will require that all participants in the MFP Demonstration or their legally authorized representative, such as a guardian -- be informed of their rights and options for LTSS under the MFP Demonstration and that participation in the MFP Demonstration is

voluntary. The informed consent process will ensure that all MFP Demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration.

The informed consent process will also include information on the range of services and supports that are available under the MFP Demonstration and any restrictions on amount, duration and scope of the covered services and supports. Additionally, supports necessary to carry out the service plan will be fully explained to the prospective MFP Demonstration participant or legally authorized representative, particularly with regard to self-directed services and supports.

As part of the informed consent process, prospective MFP Demonstration participants will be informed that (i) they can withdraw from the MFP Demonstration at any time; (ii) the MFP Demonstration period is for one year; (iii) the special demonstration services are available for one year; and (iv) that after the one year period, coverage for state plan and HCBS waiver services will continue under the rules applicable to the MassHealth program and any HCBS waiver in which the MFP Demonstration participant is enrolled as long as the MFP Demonstration participant continues to meet the eligibility requirements for the MassHealth program and the HCBS waiver services.

Ultimately, via the informed consent process, prospective MFP Demonstration participants will be given their choice to: (i) participate in the MFP Demonstration and to receive LTSS under the MFP Demonstration in lieu of receiving inpatient care in a medical facility and (ii) participate in the evaluation component of the MFP Demonstration as described in the MFP Demonstration solicitation and MFP technical assistance sessions.

Informed Consent Form

Documentation indicating that informed consent has been provided will be obtained via an *Informed Consent* Form that will be signed only by the individual approved for participation in the MFP Demonstration or those who have legal authorization to act in the individual's behalf. The *Informed Consent* Form and consent for participation in the MFP Demonstration will follow current HBCS waiver practices (in accordance with waiver guidance issued by CMS) and will be obtained during the care planning phase of the transition but prior to the delivery of home and community-based LTSS. See Appendix C for an example of an existing HCBS waiver informed consent form, which will be modified to meet MFP requirements.

Authority to Provide Informed Consent

MFP participants will be presumed competent to provide informed consent for participation in the MFP Demonstration, absent a court decision that identifies specific areas in which the person lacks capacity. For individuals who have been adjudicated incompetent and have required the appointment of a legal guardian, or where otherwise competent individuals have appointed agents to serve as substitute decision-makers in certain situations, informed consent may be obtained from the person's legal guardian, or other legally-appointed agent authorized to make health care decisions on behalf of the person.

Types of substitute decision-makers may include:

1. Legal Guardians (Full and Limited), who may be responsible for making decisions regarding the participant's medical care, property, treatment program, and/or other matters, as determined by a Massachusetts probate court. Most guardians have limited authority. A guardian must have specific authority from the probate court to consent to certain kinds of medical treatment, including antipsychotic medication.

2. A Health Care Agent, who may be chosen by a competent individual to make or communicate decisions regarding medical treatment in the event that he or she becomes incapacitated. Incapacity must be determined by a physician. The document appointing the agent is called a health care proxy or an advanced directive.

b. Guardianship under MFP

Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf of these participants. The policy should specify the level of interaction that is required by the State.

Chapter 201 of the Massachusetts General Laws describes the discretion and powers of the Massachusetts Probate Court to appoint guardians as well as the legal authority and obligations of guardians, but the law does not contain explicit requirements about levels of interaction. Under the law, the Massachusetts Probate Court may, if it appears necessary or convenient, appoint guardians of minors, mentally ill persons, mentally retarded persons, and persons unable to communicate informed decisions due to physical incapacity or illness. Legal Guardians may be responsible for making decisions regarding an MFP Participant's medical care, property, treatment program, and/or other matters, as explicitly determined by a Massachusetts Probate Court. Most guardians have limited authority. A guardian must have specific authority from the probate court to consent to certain kinds of medical treatment, including antipsychotic medication.

3. Outreach / Marketing / Education

Submit the State's outreach, marketing, education, and staff training strategy. These sections must address: a) Information communicated to enrollees, participating providers and State outreach/education/intake staff; b) types of media to be used; c) specific geographical areas to be targeted; d) locations for dissemination of information; e) staff training plans, plans for

State forums or seminars to educate the public; f) availability of bilingual materials/interpretation services and services for individuals with special needs; and g) description of how eligible individuals will be informed of cost-sharing responsibilities.

The commonwealth intends to implement a comprehensive outreach and marketing campaign that will reach facility residents, guardians, families, formal/informal supports and staff; community providers; state staff; advocacy groups; trade organizations and other interested providers. Outreach activities will occur throughout the state and will not be geographically targeted.

The outreach campaign will include the use of brochures, websites, and educational programs that will provide information on the MFP Demonstration program to potential participants, transition coordinators, participating providers, facilities, and public entities that distribute information, such as libraries, state human service agencies, ILCs, and ASAPs. As part of the outreach materials, the commonwealth will create products for distribution focused on profiles of people, such as those who will be in the MFP Demonstration program, who have successfully transitioned and that include first hand experiences from individuals and their families. These products may include newsletters, brochures and videos. A video entitled, "Community Living: Growing Opportunities and Experiences," was created to illustrate the benefits of living in the community for individuals with disabilities and discusses the range of supports available for those transitioning into the community. These resources will be publicized through Massachusetts' network of support for elders and people with disabilities and available to all state and provider entities involved in MFP participant outreach and selection.

Massachusetts' existing LTSS system is served in multiple arenas by organizations who convey information about existing programs and supports. These arenas include state agency regional and area offices, ILCs and ASAP locations. The state will leverage these locations as

well as work with facilities to locate and disseminate outreach materials. Implementation plans are being made to leverage the ILCs and Recovery Learning Communities (RLCs). RLCs have served as information hubs and locations of support for people with mental illness and addiction across the state. These centers are consumer-operated and provide consumer-run self help/peer support, information and referral, advocacy and training. These as well as other entities will play a vital role in the location and dissemination of outreach materials regarding the MFP Demonstration program.

The outreach campaign will include a comprehensive training program. State and provider staff, such as ASAP nurses and case managers, Long Term Care Options Counselors (OCs), staff of ILCs and Recovery Learning Communities (RLCs), and regionally-based state agency personnel who routinely provide informational and referral services will be trained. Staff of these organizations will be educated about the MFP Demonstration and provided with outreach materials. This will allow them to pass this information on potential MFP participants directly and personally.

Massachusetts will leverage its Long Term Care Options Counselor Training Program curriculum for some of the MFP Demonstration training curriculum. The ADRC OC training includes eight to sixteen hours in a curriculum developed and instructed by the Executive Office of Elder Affairs and the Massachusetts Rehabilitation Commission. The curriculum encompasses essential elements and criteria related to the commonwealth LTSS program and services. The training will also include a description of the transition coordination entity role and relationship to other service system components and players. The state intends to explore the availability of CEU's through its collaboration with the University of Massachusetts Medical School as a way to incentive MFP participant attendance.

Similar to the training program, the state will offer public information sessions at the statewide and regional areas. These sessions will include information on the MFP Demonstration, including specific MFP demonstration on participant eligibility criteria, demonstration services and community service options.

The strong network of supports and programs in place for potential MFP participants will allow the commonwealth to market and promote the program throughout the state. In addition to ensuring availability of materials and information in all parts of the state, Massachusetts will make every effort to ensure that all populations will have access as well.

Brochures, websites, and other resources will be produced with consideration of the needs of the general population as well as individuals with cognitive or intellectual disabilities. They will be produced in Spanish as well as English, and they will be produced in other languages, in particular, for specific geographic areas of the state. Massachusetts also makes an effort to ensure that many of our case managers, state agency staff and OCs are bilingual and able to provide services to diverse populations.

The commonwealth also will expand the accessibility of its materials beyond just translating them into other languages; we will provide brochures in Braille and large print. As a program that seeks to serve a diverse population with a range of disabilities, the staff involved in implementing MFP will be aware of the importance of making information accessible to the entire population and will lean on the commonwealth's long history of providing public information in alternative formats as requested.

In Massachusetts, there will be no cost-sharing responsibilities for Medicaid services to MFP participants, thus notification to eligible individuals is not planned.

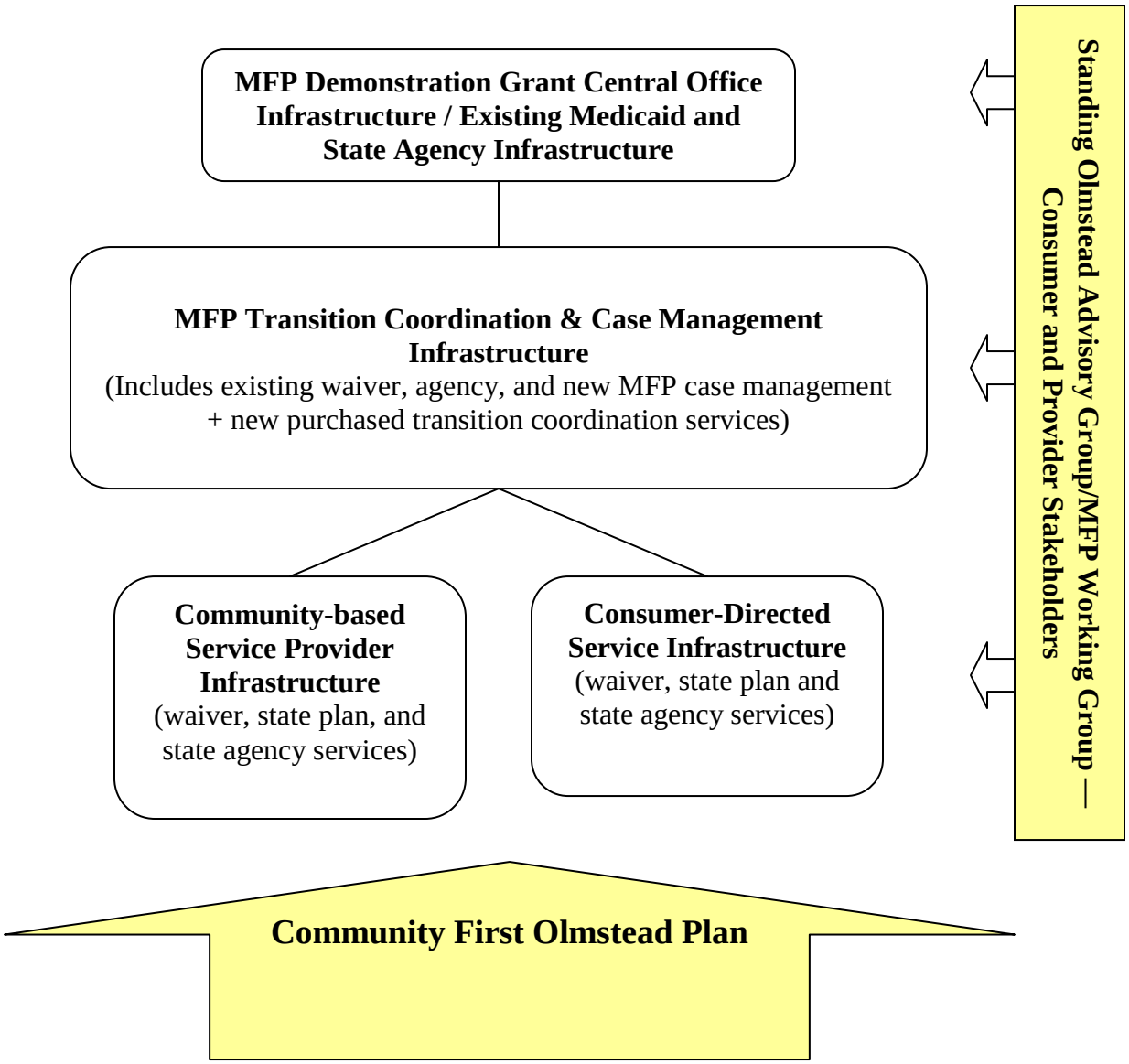
4. Stakeholder Involvement

Describe how the State will involve stakeholders including consumer representatives in the Implementation Phase of this demonstration, and how these stakeholders will be meaningfully involved throughout the life of the demonstration grant. Please include:

a. Chart that reflects how the stakeholders relate to the organizational structure of the grant and how they influence the project

The MFP Demonstration organizational infrastructure as depicted below will maintain the primary MFP Demonstration objective of assisting MFP participants to move from qualified institutional settings to qualified community residences and to be appropriately supported with community-based services. The organizational chart below shows at a high level the various levels of MFP Demonstration infrastructure and how these levels are:

- supported by the Community First Olmstead Plan which was developed with consumer and provider stakeholder input; and
- continually informed by a standing Community First Olmstead Committee/MFP Working Group which consists of a wide range of interested stakeholders, including consumers, advocates, and provider groups.



b. Brief description of how consumers will be involved in the demonstration

The Community First Olmstead Plan, which was developed collaboratively with consumers, advocates, and community and institutional providers, provides the policy platform for the commonwealth's rebalancing activities, of which the MFP Demonstration will be a crucial component. The Olmstead Plan includes initiatives related to enhancing transitions from facilities to the community, quality improvement, rebalancing of LTSS financing and

expanding access to the HCBS infrastructure. The MFP Demonstration provides an operational mechanism for many of these goals contained in the Community First Olmstead Plan. Consumers will be involved in the MFP Demonstration through their participation in the MFP Working Group, a subgroup of the Community First Standing Olmstead Advisory Group. The Standing Olmstead Advisory Group was established as a recommendation at the culmination of Massachusetts' Systems Transformation Grant in the Fall of 2010, and will meet periodically throughout the Demonstration period.

The MFP Working Group was established to collaborate with and advise the commonwealth as it developed the MFP Demonstration application, and will continue to meet at least semi-annually throughout the MFP Demonstration period. The group will be a vehicle for consumers and other stakeholders to provide ongoing input on relevant policy design and operational details of Demonstration implementation. As consumers are identified for and assisted in their transition, the commonwealth will make efforts to engage select MFP participants in this MFP Working Group as well.

In general, the commonwealth requires of its contracted providers that consumers be involved with their organizations through consumer advisory boards. The commonwealth fully anticipates that this will continue to be a requirement for MFP participating case management entities as well as direct service providers. The commonwealth will hire and contract with consumers to provide the critical supports which Peer Support workers can provide during a transition to community living. The commonwealth will encourage consumers and consumer run organizations including ILCs and RLCs to provide services through the Demonstration when they meet the qualified provider requirements for MFP, HCBS waiver, and/or state agency programs.

The state agencies that support consumers with HCBS waivers and programs also maintain consumer advisory groups for various functions. The commonwealth anticipates that these groups will be able to provide population specific MFP Demonstration input during the demonstration as needed. Additionally, the commonwealth has had experience working directly with consumer groups to develop outreach materials and education campaigns. For example, the Massachusetts Rehabilitation Commission and MassHealth collaborated with the Brain Injury Association of Massachusetts to develop outreach materials and a series of presentations for potential consumers/family members and advocates related to the ABI waiver which began enrolling individuals in May 2010. The Department of Developmental Services also engaged with consumer stakeholders in the evaluation of service delivery system quality data. Some of these practices may be replicated with consumer representatives during the MFP Demonstration.

c. Brief description of community and institutional providers' involvement in the demonstration

In addition to providing direct services to MFP Demonstration participants, providers will continue to play an active role in the Standing Olmstead Advisory Group. The State also maintains several ongoing working groups with both community and institutional providers which will facilitate an open dialogue with regard to problem solving and policy input throughout MFP Demonstration implementation. These groups include but are not limited to: the Massachusetts Senior Care Association/MassAging/MassHealth monthly operations meeting which brings together Medicaid agency representatives and representatives from the two nursing facility trade organizations in the state; the Mental Health Planning Council, which meets quarterly; and the PCA Prior Authorization Design Workgroup.

d. Description of the consumers' and community and institutional providers' roles and

responsibilities throughout the demonstration

Consumers and community and institutional providers' roles and responsibilities on the MFP Working Group and, more generally, on the Olmstead Advisory groups will be to:

- Attend regularly scheduled meetings;
- Share information in a timely manner with their constituency groups;
- Represent the diverse voices of the constituencies they represent;
- Respond in a timely manner to requests for information; and
- Communicate openly and respectfully with other Advisory Group participants.

e. Operational activities in which the consumers and community and institutional providers are involved

Consumers and community and institutional providers will be involved with outreach activities for the MFP Demonstration. Consumers will, through the MFP Working Group, provide input into ongoing operational design issues that are brought to this group. Community and institutional providers will contract with the state to provide services and supports to Demonstration participants.

5. Benefits and Services

a. Description of the Service Delivery System (for Each Population)

Delivery mechanism and Medicaid mechanism through which qualified HCBS will be provided at the end of the Demonstration period; For Demonstration and supplemental services, detail the plan for providers or the network used to deliver those services.

All HCBS provided through MFP will be available and provided through approved HCBS waivers or the State Plan. Demonstration Services will be provided to every MFP participant through 365 days of community residence. We anticipate that by the end of the

Demonstration providers who have been delivering demonstration services will also be providing other ongoing LTSS and will have become part of the expanding MassHealth community-based services provider base made possible by enhanced federal Medicaid funding and infrastructure development opportunities afforded by the MFP demonstration.

MassHealth will provide HCBS to MFP-transitioned members beyond the demonstration period using the following delivery mechanisms:

Frail Elder HCBS waiver: under both 1915(a) and 1915(c) authority HCBS will be provided to enrolled elders. For waiver participants enrolled in SCO managed care plans, HCBS are included in the capitation rate for the plan. Waiver participants who are not enrolled in SCO receive HCBS services on a fee-for-service basis.

DDS waivers: under 1915(c) authority HCBS will be provided to people with intellectual disabilities through 3 separate waivers. HCBS services are paid on a fee-for-service basis. Through 1115 demonstration authority, persons under the age of 65 may receive behavioral health diversionary services on a capitated basis.

Brain Injury waivers: under 1915(c) authority HCBS will be provided to enrolled people with acquired and traumatic brain injury though 3 separate waivers. HCBS services are paid on a fee-for-service basis. Through 1115 demonstration authority, persons under the age of 65 may receive behavioral health diversionary services on a capitated basis.

MFP waivers: MassHealth will apply for 1915(c) authority to provide HCBS to enrolled adults of any diagnosis or age who have transitioned from a qualified institution. HCBS services would be paid on a fee-for-service basis. Through 1115 demonstration authority, persons under the age of 65 may receive behavioral health diversionary services on a capitated basis.

MFP participants who do not need waiver services or chose not to enroll in an HCBS waiver will receive most State Plan HCBS on a fee-for-service. Through 1115 demonstration authority, persons under the age of 65 may receive behavioral health diversionary services and certain other health services on a capitated basis.

b. Service Package Available (for Each Population)

Only those provided through MFP demonstration (not acute et al). Divide list in chart by Qualified HCBS, HCBS Demonstration Services and Supplemental Services. If any Qualified HCBS are not currently available to Medicaid recipients (and, thus, not included in MOE calculations), detail when/how they'll be added to Medicaid. For HCBS Demonstration and Supplemental Services indicate the billable unit of service and proposed rate. For Supplemental Services, provide medical necessity criteria and provider qualifications.

Table 5.B.1 Qualified HCBS Services

Service Type	Service	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Frail Elder Waiver (EOEA)	ABI – RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)	MFP Community Living Waiver (NEW)	MFP Qualified Individuals receiving state plan services (but no HCBS waiver services)
Home and Community Based Services	Adult Companion	X		X		X		X	
	Agency Personal Care			X		X		X	
	Assistive Technology / Specialized Medical Equipment	X[6]	X	X[7]	X	X	X	X	
	Behavioral Health						X	X	
	Behavioral Supports and Consultation	X	X						
	Bundled Supportive Home Services						X		
	Chore Service	X		X		X		X	
	Community Based / Expanded Substance Abuse Treatment				X	X	X	X	
	Day Habilitation Supplement	X	X						
	Day Services	X[8]	X[8]	X[9]	X	X	X	X	

[6] Includes Specialized Medical Equipment and Supplies
[7] This service in Frail Elder Waiver is Home Based Wandering Response System
[8] Includes Group or Center Based Day Services
[9] Supportive Day Program for Frail Elder Waiver

Service Type	Service	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Frail Elder Waiver (EOEA)	ABI – RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)	MFP Community Living Waiver (NEW)	MFP Qualified Individuals receiving state plan services (but no HCBS waiver services)
	Family Training	X[10]	X[11]				X[12]	X[12]	
	Grocery Shopping and Home Delivery			X				X	
	Home / Environmental Accessibility Modifications	X[13]	X[13]	X		X[14]	X	X	
	Home Health Aide			X				X	
	Homemaker	X		X		X		X	
	Home-Delivered Meals			X				X	
	Individual Goods and Services	X	X						
	Individual Support and Community Habilitation[15]					X	X	X	
	Individualized Day Supports	X	X						
	Individualized Home Supports	X							
	Laundry			X				X	
	Live-in Caregiver	X							

[10] Service titled Community Family Training
[11] Service titled Residential Family Training
[12] Service titled Family Support and Training
[13] Service titled Home Modifications and Adaptations
[14] Service titled Home Accessibility Adaptations
[15] Among other types of supports, individual supports can include services to enable individuals to self-direct, where necessary, and when no other support is available to the participant.

Service Type	Service	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Frail Elder Waiver (EOEA)	ABI – RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)	MFP Community Living Waiver (NEW)	MFP Qualified Individuals receiving state plan services (but no HCBS waiver services)
	Medication Management							X	
	Non-medical Transportation	X	X	X	X	X	X	X	
	Occupational Therapy	X	X		X	X	X	X	
	Peer Counseling	X[16]	X[17]				X	X	
	Physical Therapy	X	X		X	X	X	X	
	Residential Habilitation		X		X		X[18]		
	Respite	X	X	X		X	X	X	
	Self-Directed 24 Hour Supports		X						
	Shared Living						X	X	
	Skilled Nursing			X			X	X	
	Speech Therapy	X	X		X	X	X	X	
	Stabilization	X	X						
	Supported Employment	X	X		X	X	X[19]	X[19]	
	Supportive Home Care Aide			X				X	

[16] Service titled Community Peer Support
[17] Service titled Residential Peer Support
[18] Includes Residential Habilitation Level 1 and Level 2

[19] Service titled Supported Employment Services – CIES Model

Service Type	Service	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Frail Elder Waiver (EOEA)	ABI – RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)	MFP Community Living Waiver (NEW)	MFP Qualified Individuals receiving state plan services (but no HCBS waiver services)
	Transitional Assistance Services	X	X	X	X	X			
	Vehicle Modification	X						X	
State Plan Services (Qualified HCBS—State Plan and 1115 Demonstration (managed care) services)* *This includes populations enrolled in SCO and PACE[20]	Adult Day Health	X	X	X	X	X	X	X	X
	Adult Foster Care	X	X	X	X	X	X	X	X
	Audiologist Services	X	X	X	X	X	X	X	X
	Chronic Disease and Rehabilitation Hospital Outpatient	X	X	X	X	X	X	X	X
	Community Health Center	X	X	X	X	X	X	X	X
	Day Habilitation	X	X	X	X	X	X	X	X
	Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
	Durable Medical Equipment and Supplies	X	X	X	X	X	X	X	X
	Hearing Aides	X	X	X	X	X	X	X	X
	Home Health	X	X	X	X	X	X	X	X
	Hospice (Non-Facility Setting)	X	X	X	X	X	X	X	X
	Medically Necessary Non-	X	X	X	X	X	X	X	X

[20] SCO and PACE offer Home and Community Based Services similar to those available in Frail Elder Waiver

Service Type	Service	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Frail Elder Waiver (EOEA)	ABI – RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)	MFP Community Living Waiver (NEW)	MFP Qualified Individuals receiving state plan services (but no HCBS waiver services)
	emergency Transportation								
	Mental Health Services	X	X	X	X	X	X	X	X
	Orthotic Services	X	X	X	X	X	X	X	X
	Oxygen and Respiratory Therapy Equipment	X	X	X	X	X	X	X	X
	Personal Care	X	X	X	X	X	X	X	X
	Private Duty Nursing	X	X	X	X	X	X	X	X
	Prosthetics	X	X	X	X	X	X	X	X
	Rehabilitation	X	X	X	X	X	X	X	X
	Speech and Hearing Services	X	X	X	X	X	X	X	X
	Targeted Case Management	X	X						
	Therapy: Physical, Occupational, and Speech/Language	X	X	X	X	X	X	X	X
	Vision Care	X	X	X	X	X	X	X	X
Demonstration Services	Assistive Technology								X
	Case Management								X
	Mobility Training								X

Service Type	Service	Community Living Waiver (DDS)	Adult Residential Waiver (DDS)	Frail Elder Waiver (EOEA)	ABI – RH Waiver (MRC)	ABI –Non-Residential Waiver (MRC)	MFP Residential Waiver (NEW)	MFP Community Living Waiver (NEW)	MFP Qualified Individuals receiving state plan services (but no HCBS waiver services)
	Transitional Assistance[21]	X	X	X	X	X	X	X	X

[21] Transitional Assistance Services may include such components as: Non-recurring set-up expenses (security deposits, essential furnishings, pest eradication, etc.), environmental adaptations, adaptive equipment, assistive technology; pre-discharge assessment by an RN and OT (related to home navigation, medication self-management, chronic disease self-management, need for Care Transition Counseling), peer support and companion services, activities to assess need, arrange for and procure needed resources (individual support, transportation), service animals, Family support/training, Community re-integration, 24 hour services, (i.e. personal care services and/or peer/companion support for a specified post-transition period), Housing locator/roommate matching, telehealth monitoring or reminders, substance abuse treatment, cognitive adaptive training

Table 5.B.2 Demonstration and Services Detail

Cost Type	Service	Waivers Affected	Users of State Plan Services (not in a waiver)	Provider	Rate	Caps on Utilization	Start Date
Demonstration Services	Transitional Assistance Services	MFP-R, MFP-CL	X	contracted	per 114.3 CMR 54.00	certain components	July 2011 (state plan users) July 2012 (MFP waivers)
	Mobility Training		X	contracted	TBD	no	July 2011
	Assistive Technology		X	contracted	per 114.3 CMR 22.00	certain types	July 2011
	Case Management		X	contracted	$63.14 PMPM (estimated)	no	July 2011
Demonstration Administrative Cost	Case Management	MFP-R, MFP-CL		contracted	$63.14 PMPM (estimated)	no	July 2012

Table 5.B.3 Administrative Activities

Administrative Costs - Type	Admin Activity	DDS-R	DDS-CL	FEW	ABI-RH	ABI-N	MFP-R	MFP-CL	Provider	Rate	Start Date
Administration - Cost of Populations	DDS Adult Waivers (Cost Allocation Plan - agency cost)	X	X						agency admin		currently operational
	Frail Elder Waiver (Admin portion)			X					contracted		currently operational
	MRC ISA, allocated				X	X			ISA		currently operational
Case Management - Cost of Populations	New MFP Waivers						X	X	contracted	$63.14 PMPM (estimated)	July 2012

6. Consumer Supports

Describe the process and activities that the State will implement to ensure that the participants have access to the assistance and support that is available under the demonstration, including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services. Please provide:

a. A copy of the educational materials used to convey procedures the State will implement in order for the demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available.

Educational materials will describe the MFP Demonstration program, as well as the network of community based LTSS that will be available to MFP participants. Materials will address questions of eligibility, access to the program, contact persons/programs from which a potential consumer can obtain information about the program, and information about the various web-based sources of information on community based programs, LTSS, and resources available to individuals, their representatives, family, caregivers and friends. In addition to information about the MFP Demonstration program, specific information will be developed and made widely available about various aspects of the state's ability to support MFP participants post-discharge, including:

- State plan services, how these services would meet an individual's needs and how they can be accessed;
- HCBS waivers, the specific populations that may be served by the various existing waivers offered in Massachusetts, contact and access information related to the waivers;
- Descriptions and information about new HCBS waivers for MFP participants who may not find existing waivers either accessible or able to meet their needs;

- State agency resources and programs that may provide assistance to those transitioning from facilities;
- Opportunities for participants to self direct their services and supports, and explanations of available vehicles that will support self direction; and
- Other information found to be necessary that will be developed as the MFP Demonstration program takes shape and is implemented.

Examples of current educational materials for participants across the service system include (see Appendix D):

- DDS waivers and Agency Services Information;
- Home Modification Loan and MassAccess Housing Registry; and
- MassHealth Personal Care Attendant Program / Personal Care Attendant Registry Information.

Massachusetts' existing community-based LTSS system is served in multiple arenas by organizations that have a responsibility to convey information about existing programs and supports. Resources include CSSM interdisciplinary teams, Long Term Care Options Counselors (OCs), LTC Ombudsmen, and regionally-based MRC, DDS and DMH state agency staff and contracted RLC peer supports specialists. CSSM nurses and case managers, employed through ASAPs, are deployed around the state to visit individual nursing facility residents to determine their appropriateness for a Medicaid-paid nursing facility stay. With direct access to such individuals, this staff provides a wealth of information to them and their families about community-based alternatives through which needed LTSS can be made available. Similarly, staff providing options counseling provide information about community LTSS and referral to

nursing facility patients and individuals in other facilities. These personnel, a component of ADRCs operating around the state, make information and materials available to any patient, not only those who may be converting to MassHealth.

These broad efforts are supported more directly and specifically through the efforts of the multiple state agency operated HCBS waivers, programs, and services that currently provide LTSS in Massachusetts to a variety of populations. Case management is provided to individuals who are currently served through these programs and will be expanded through the MFP Demonstration to ensure that MFP participants who utilize state plan services only receive Demonstration case management, and that those in the two proposed MFP waivers receive administrative case management. The state expects to provide case management for MFP participants through the following existing or planned programs:

Agency/Program	Program(s)
Department of Developmental Services	Waivers serving adults with intellectual disabilities
Executive Office of Elder Affairs	Frail Elder waiver
Massachusetts Rehabilitation Commission	Acquired Brain Injury waivers; proposed MFP waivers
Department of Mental Health	State employee case management; various community supports
MFP Demonstration Program	MFP Demonstration case management

The case manager is the lynchpin of the LTSS system in terms of providing information, education and specifics about procedures to individuals served through these programs as well as those seeking and/or being determined eligible for LTSS. It is common practice for case managers to provide educational materials to participants upon initial meetings. These materials convey procedures and policies in place that ensure participants can access the services and

supports they need, have thorough information and reference material to utilize and share with family members, as well as an individual – the case manager – of whom they can ask questions or who they may contact later with other inquiries. In developing additional options for MFP participants, Massachusetts will ensure that case management resources are in place for both individuals in MFP who already have case management through state agency supports and waiver programs, for those who end up being served through new MFP waivers, as well as to consumers who transition to the community with state plan supports only. Case managers will, among a great many other responsibilities, ensure the provision of educational materials, and information so that demonstration participants, regardless of the vehicle through which they access community services and supports, have needed assistance, supports and information about how to access the resources that are available to them.

Other methods of providing this type of information will complement the efforts of these direct contact resources and include posting information on the MFP Demonstration website, development of specific pamphlets or other materials, as well as possibly conducting outreach sessions in conjunction with advocacy organizations, and/or providers, (e.g. Brain Injury Association of Massachusetts, ARC, Mass Home Care, etc.)

MFP Demonstration information will be disseminated to other existing sources and groups for use and distribution along with information they currently utilize that provides consumers with details about available community formal and informal supports for specific population groups. These other resources for finding information and appropriate community based supports are widely available and include:

- Mass Aging and Disability Information Locator (MADIL)
- The New England Index

- Independent Living Centers (ILCs)
- Aging Service Access Points (ASAPs) and Area Agencies on Aging (AAAs)
- 800AgeInfo.com and 800-Age-Info (telephone access)
- Recovery Learning Communities (RLCs) (resources for persons with mental illnesses)
- DMH and DDS regional offices

The MFP Demonstration will allow Massachusetts to create greater cross-agency and cross-population cohesion in the message, materials and resources available to MFP qualified individuals seeking transition. Building on the foundation of our existing experience and resources, MFP will provide the impetus and financing to round out the state's approach to educating consumers.

b. A description of any 24-hour back-up systems accessible by demonstration participants including services and supports that are available and how the demonstration participants can access the information (such as a toll free telephone number and/or website). Include information for back-up systems including but not limited to:
    i. Transportation
    ii. Direct service workers
    iii. Repair and replacement for durable medical and other equipment (and provision of loan equipment while repairs are made); and
    iv. Access to medical care: individual is assisted with initial appointments, how to make appointments and deal with problems and issues with appointments and how to get care issues resolved.

Back-up Plans

The development of a back-up plan for each MFP participant will be an important component of Massachusetts' approach to the MFP Demonstration program. Each MFP participant, no matter which delivery system s/he elects, will have an individualized back-up plan that will be developed with the participant with the assistance of a case manager. Back-up response will rely on existing capacity within state agencies, service providers with which they

contract, and administrative structures they may operate. In addition, the state will develop case management capacity to support MFP participants who enroll in an MFP waiver or who receive state plan services, and this resource will be responsible to provide 24/7 back-up response to these participants.

Working with the participant, the case manager will be responsible for ensuring that an individualized 24/7 back-up plan is developed, that it addresses issues such as transportation, the availability of direct service workers, repair and replacement of durable medical equipment, and access to medical care, as required by the Demonstration, and that the participant understands exactly what to do when he/she needs back-up.

Each MFP participant will work with their case manager and care planning team to develop an appropriate back-up plan, as a component of their person-centered plan of care. As part of the assessment, consumer needs and characteristics relative to the back-up plan will be reviewed, such as how long the consumer can be alone and what types of personal care assistance are needed. In addition, specific risk factors will be identified in the areas of health, behavior, and personal safety. With this information, a written plan will be developed that coordinates HCBS waiver services, state plan services, direct service providers and informal supports to ensure all of the consumer's needs are met on a 24-hour basis. Each person, provider and organization will be aware of, and agree to, their part in the back-up plan to ensure that the plan can be implemented smoothly and efficiently.

An MFP participant's case manager will provide the participant with a 24-hour contact number that connects him/her with an emergency back-up on-call system, essentially an on-call case manager, who is able to intercede and arrange for urgent care. The on-call case manager will have access to essential consumer information, including the consumer's individual back-up

plan. The on-call case manager will be able to authorize services to be immediately delivered, contact persons or organizations responsible for elements of the back-up plan, call for medical assistance, and otherwise ensure that the consumer's presenting needs are met. The on-call case manager would then be responsible for communicating with the consumer's primary case manager regarding the issues and interventions to ensure appropriate follow up.

As with all MFP participants, those who self-direct some or all of their services must formulate back-up plans in the event that staff cannot keep to the expected schedule or something unforeseen arises. Case managers and support brokers will play key roles in assisting individuals to have these plans in place.

Case managers will work with each MFP participant to monitor the use and success or failure of back-up plans and, at any point necessary, make changes to the back-up plan to resolve problems that arise, or to take into account changing circumstances.

As a supplement to individual specific back-up plans, the state will be considering how to leverage pools of direct care workers as back-up/temporary staff to assist participants as needed. These efforts will include evaluating how the existing Personal Care Attendant Directory (PCA Directory) (www.rewardingwork.org) could be used effectively as a source of emergency back-up workers, and also how Certified Nursing Assistants employed by nursing facilities could be added to the PCA Registry as a potential pool of back-up workers.

c. A copy of the complaint and resolution process when the back-up systems and supports do not work and how remediation to address such issues will occur.

MONEY FOLLOWS THE PERSON

Complaint Procedure

Background/Purpose:

Participants in the MFP Demonstration program must understand their right to complain and have opportunities to register complaints about various aspects of their experience within the program. Such complaints may include, for example, issues with back-up plans or execution of back-up plans, dissatisfaction with the MFP Program or its staff, or the participant's MFP case manager. The MFP Program Director will identify a coordinator(s) for all participant complaints, maintain a *Complaint Log* and develop a document that explains the processes by which an MFP participant may file a complaint. MFP participants will receive information about complaints at the time of their Service Plan development and review it with their case manager then and annually during the redetermination for eligibility process.

Definitions:

Complaint: An informal oral or written expression of dissatisfaction by an MFP participant, an MFP participant's family member or representative with issues with back-up plans or execution of back-up plans, dissatisfaction with the MFP Program or its staff, or the participant's MFP case manager. This is a request for action by the MFP participant.

MFP participant: A person determined by the MFP Program (the Program) to be eligible for and enrolled as an MFP qualified individual.

Policy:

Any MFP participant has the right to register a complaint with the Program about dissatisfaction with the MFP Program or its staff, the participant's MFP case manager or about issues with back-up plans or execution of back-up plans,. The Program will record all complaints it receives in a *Complaint Log*, and shall respond within 24 hours or one business day to any complaint and resolve that complaint within 15 business days of receipt. Reason for any delay in resolving the complaint must be documented in the *Complaint Log.* The Program will document

the disposition of any complaint in the *Complaint Log*. The *Complaint Log* must be reviewed by the MFP Program Director on a monthly basis. Upon request, the *Complaint Log* will be sent to the Executive Office of Health and Human Services (EOHHS) Office of Medicaid and/or the waiver operating agency, as appropriate. See Appendix E for a draft MFP Complaint procedure.

7. Self-Direction

Sub-Appendix I is considered part of the Operational Protocol and is required for States using self-direction for MFP demonstration participants. An electronic copy of the form will be made available to applicants. CMS requires that adequate and effective self-directed supports are in place. Provide a description of the self-direction opportunities under the demonstration before the Institutional Review Board (IRP) approval.

In addition to completing Appendix A [Sub-Appendix I?], please respond to the following:

a. Describe how the State accommodates a participant who voluntarily terminates self-direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method.

Self-direction opportunities for MFP Demonstration participants will be made available through existing or planned HCBS waivers, as well as through the state plan Personal Care Attendant (PCA) program. Each of these self-directed supports and programs are delineated in separate Self-Direction Submittal Forms (Sub-Appendix I) in Appendix F. In the case of an HCBS waiver participant who wishes to voluntarily terminate self direction, repeated efforts will be made by the case manager and Support Broker to sustain the participant in his/her self-direction of services. If after multiple efforts, the waiver participant voluntarily chooses to terminate this method of receiving services, it will be the responsibility of the case manager to arrange for and ensure continuity of services/supports through traditional providers to meet the individual's health and welfare needs outlined in their person-centered plan of care. When appropriate, the case manager will work with the participant to adjust the service plan to ensure

that it meets the needs and desires of the participant and to ensure health and safety during the transition from participant-directed services to more traditional provider based services.

Massachusetts' PCA program is a self-directed, employer-authority model that provides opportunity for members to hire personal care workers of their choosing. This state plan service is not available to members who do not wish to self direct.

b. Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition.

Each waiver participant who self-directs will develop an Agreement for Self Directed Supports describing the expectations of participation. Breach of any of the requirements with or without intent may disqualify the individual from self-directing-services. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self Directed Supports.

Although the State will work to prevent situations of involuntary termination of self-direction, they may be necessary. If it is necessary to involuntarily terminate a participant's involvement in a self-directed waiver program/service, the participant will be given notice and an opportunity for a fair hearing. Reasons for termination include but are not limited to refusal on the part of the participant to be involved in the person-centered planning process and/or the development and implementation of the plan of care, authorization of payment for services or supports that are not in accordance with the individual service plan, commission of fraudulent or criminal activity associated with self-direction, demonstration that a surrogate is needed (and decline of such surrogate when informed it is necessary) to ensure adequate management of the

budget, on-going ability to locate, supervise, and retain employees, and to submit time-sheets in a timely manner, and other individual circumstances that may preclude continued self direction.

In the case of an involuntary termination of participant self-direction, the individual and the support team meet to develop a transition plan and modify the Waiver Plan of Care. It is the responsibility of the participant's case manager to ensure that the participant's health and safety needs are met during the transition, to coordinate the transition of services and to assist the individual to choose a qualified provider to replace the directly hired staff.

c. Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.

The following table shows the State's goals for the percentage of participants in two new MFP waivers who will choose to self direct services, for each year that the demonstration is in effect. Massachusetts will report annually to CMS the number of participants who elect to direct their Demonstration services.

	Budget Authority Only or Budget Authority in Combination with Employer Authority
Demonstration Year	**Number of Participants**
Year 1	Estimated 5% of participants under 65 years of age. Estimated 1% of participants over 65 years of age.
Year 2	Estimated 10% of participants under 65 years of age. Estimated 2% of participants over 65 years of age.
Year 3	Estimated 15% of participants under 65 years of age. Estimated 3% of participants over 65 years of age.
Year 4	Estimated 20% of participants under 65 years of age. Estimated 4% of participants over 65 years of age.
Year 5	Estimated 20% of participants under 65 years of age. Estimated 4% of participants over 65 years of age.

8. Quality

Describe State's QI system (QIS) for demonstration participants during the demo year and after. Demonstrate how services during the 365 day period will: be utilized to inform CMS

demonstration evaluation and meet/exceed guidance for QIS in Version 3.5 of 1915(c) waiver application. Certain descriptions required depending on whether states plans to:

a. Integrate MFP into new/existing 1915(c) waiver or HCBS SPA
b. Utilize existing 1915(b), SPA, or 1115 Waiver
c. QIS under the MFP must address 6 waiver assurances in Version 3.5
d. If State provides supplemental services

Massachusetts assures the Centers for Medicare and Medicaid Services (CMS) that quality assurance and quality improvement standards for the MFP demonstration will be applied at the same level or higher as the guidance for quality improvement systems (QIS) set forth in version 3.5 of the 1915 (c) waiver application. The state further assures CMS that MFP transitions will have a comprehensive and integrated QIS that will utilize critical processes of discovery, remediation and systems improvement that will occur in a structured and routine manner. The state will conduct level of care assessments to determine that participants are at an institutional level of care and that plans of care are responsive to participant needs. The MFP Demonstration quality management structure will ensure qualified providers serve waiver participants and maintain the health and welfare of participants. The state Medicaid agency retains administrative authority and financial accountability for the Demonstration. The state's MFP QIS across all of its HCBS waiver programs is designed to be a comprehensive and integrated quality management strategy that will enhance the state's capacity to assure that its long-term supports system operates as designed.

Massachusetts is offering MFP Demonstration services to adults age 18 and older through multiple existing HCBS waivers, two new HCBS waivers to be submitted to CMS to cover adult populations not otherwise covered by those existing HCBS waivers, and existing state plan services and delivery systems.

All of Massachusetts' currently operating HCBS waivers address the waiver assurances and Appendix H in version 3.5 of the 1915(c) HCBS waiver application, and the two new HCBS waivers to be submitted to CMS for approval will utilize version 3.5. The commonwealth's quality management system for the HCBS waivers will be used during the 365-day MFP Demonstration eligibility period and after transition from the demonstration.

Massachusetts' MFP services provided and monitored through the QIS structures mentioned above and more specifically referenced below will inform the CMS evaluation of the state's MFP Demonstration. Quality assurances and quality improvement procedures in place will inform CMS that needed services are being provided in the community. Further, the state will provide demonstration service utilization data and track community status for all MFP Demonstration participants. Data will show MFP service utilization and length of time individuals remain living in the community by tracking community status at six months, one year and two years after MFP eligibility ends. This information with results from the Quality of Life survey will enable CMS to identify services used that supported individuals in the community and how quality of life is affected by the transition program.

The state's QIS system will balance the need to provide consumer choice and opportunities to self-direct services and the need to ensure that appropriate safeguards are in place to assure the health and safety of participants. It is designed to assure that essential safeguards are met with respect to health, safety and quality of life for all members. The state currently has a robust system in place which continues to evolve using the following three operational principles: 1) the system is designed to create a continuous loop of quality assessment and initiation of improvement including the identification of issues, notification to concerned parties, remediation, follow-up analysis of patterns and trends, and improvement

activities; 2) quality is measured based upon a set of outcome measures agreed upon by waiver stakeholders, which are based on the fundamental purposes of the waivers and programs, CMS assurances, Massachusetts' regulations and quality goals; and 3) the system also assesses quality by measuring health and safety for participants and places a strong emphasis on other quality of life indicators including participant access, person-centered planning and service delivery, rights and responsibilities, participant satisfaction and consumer involvement.

Massachusetts' quality improvement strategies approach quality from three perspectives: the individual, the provider and the system. On each tier, the focus is on discovery of issues, remediation and service improvement. Information gathered on the individual and provider level is used not only to remedy situations on those levels, but also to inform overall system performance efforts. Massachusetts QIS strategy also includes ongoing assessment and quality improvement activities related to cultural and linguistic competencies through activities that include stakeholder input, integration of measures into internal audits, and evaluation of services and programs. Massachusetts will use the same approach for the MFP Demonstration.

QIS for MFP Eligibility Period – Existing HCBS Waiver Programs

Each of the current HCBS waiver programs MFP participants may access for community-based care during and after MFP Demonstration eligibility ends currently have comprehensive quality plans in place as part of the CMS-approved version 3.5 waiver applications. The MFP Demonstration program will possess the same level of quality assurance and improvement activities articulated in appendix H of the existing 1915(c) HCBS waiver applications. The five waiver programs include:

1. Acquired Brain Injury Non-Residential Habilitation (40702.R00.00)
2. Acquired Brain Injury with Residential Habilitation (40701.R00.00)

3. Adult Residential (0827.R00.00)
4. Community Living (0826.R00.00)
5. Frail Elder (0059.R05.01)

See Appendix G for the waiver cycle of these existing HCBS waivers.

The MFP QIS will specifically address and follow all of the assurances articulated in the approved version 3.5 application including those relative to level of care determinations; service plan description; identification of qualified HCBS waiver providers for those participants being transitioned; health and welfare; administrative authority; and financial accountability. As reflected in the CMS-approved 3.5 waiver applications, the QIS will use continuous quality improvement activities that will be used to discover and remediate problems. All individuals transitioning from the MFP Demonstration to HCBS waiver services will be monitored to ensure adequate oversight to discover and remediate problems.

QIS for MFP Eligibility Period – Planned MFP HCBS Waivers

Massachusetts will submit two MFP HBCS waiver applications to support MFP participants after discharge from facility-based settings to the community. These waivers will provide HCBS to demonstration participants who would not be eligible for one of the existing HCBS waivers listed above. The planned HBCS waivers are the MFP Residential Supports Waiver and the MFP Community Living Waiver.

The MFP Residential Supports and MFP Community Living Waivers will include all CMS assurances required as part of the version 3.5 HCBS waiver application and include the state's consistent approach to quality across the waivers included in Appendix H of the existing CMS-approved HCBS waivers.

The MFP Residential Supports Waiver will include a complement of home and community-based services that will include residential habilitation, shared living and bundled supportive home services. The MFP Community Living Waiver will also provide a complement of home and community-based services but will not include residential habilitation or bundled supportive home services. Both will include the opportunity for individuals to self-direct some of their services. As reflected in the state's existing approved HCBS waiver applications, the quality management and improvement system will balance the need to assure that appropriate safeguards are in place with the need to preserve individual and family choice and control, the foundational principle of self-directed supports. QIS will be conducted as continuous quality improvement activities that will be used to discover and remediate problems.

QIS for MFP Eligibility Period – Supplemental Demonstration Services

The commonwealth is not proposing to provide supplemental demonstration services under the MFP Demonstration.

Systems Post MFP Eligibility Period

MFP qualified participants who remain eligible for MassHealth post their initial 365 day transition period will continue to be supported through appropriate MassHealth LTSS to maintain their tenure and to thrive in the community. It may be anticipated that most will stay with the services, programs and mechanisms they will have utilized while receiving demonstration services during the MFP transition period. Individuals and their providers will be familiar with the process for providing continued input to identify and remediate problems.

9. Housing

a. Defining and Documenting Qualified Residences

Describe the State's process for documenting the type of residence in which each participant is living. The process should categorize each setting in which an MFP participant resides by its type of "qualified residence" and by how the State defines the supported housing setting (such as owned/rented by individual; group home; adult foster care home; assisted living facility; etc.). If appropriate, identify how each setting is regulated.

There are three types of qualified residences in which MFP participants can choose to reside:

1. A home owned or leased by the individual or the individual's family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.
3. A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

The MFP participant's case manager will work to identify and document the type of qualified residence where each MFP participant chooses to live based on their needs and preferences. Case managers will discuss all options with the MFP participant. A standardized form will be created to capture housing information, categorized by type of qualified residence and by how the state defines the setting, as noted in the table below, for each MFP participant and the necessary documentation showing how qualification was verified will be submitted to the MFP Project Director within the Office of Medicaid.

Framework for Documenting MFP Participant's Type of Residence

Type of Qualified Residence	Number of Each Type of Qualified Residences	State Definition of Housing Settings	Number in Each Setting	How Regulated
Home owned or leased by individual or individual's family member		• Home leased by individual or family • Home owned by individual • Home owned by family		• Lease with landlord • N/A • N/A
Apartment with an individual lease, lockable access & egress, & which includes living, sleeping, bathing & cooking areas over which the individual or the individual's family has domain & control.		• Apartment building • Assisted living • Public housing units		• Lease with landlord • State regulations • Public Housing Agency
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.		• Adult foster care • Group home		• MassHealth regulations • Agency regulations • State contracts

Housing coordinators assisting with community placements will be trained to identify qualified settings prior to commencing placement efforts for MFP participants. Housing coordinators will verify that homes or apartments meet the statutory definitions under the MFP

Demonstration. Verifications may be based on a visit to the residence, a report of the consumer or representative, information obtained from the property manager or landlord, licensure information, or information from a local housing authority. Information about the qualified residence, and how qualification was verified, will be recorded in the individual's record and reported to Office of Medicaid prior to transition to that residence.

b. Strategies to Achieve Supply of Qualified Residences/Meet the Projected Housing Need

Describe existing/planned inventories or needs assessments of accessible/affordably housing; explain how state will address any identified housing shortages for MFP participants; address how Medicaid and MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet the need; identify State strategies for promoting availability, affordability and accessibility of housing for MFP participants.

I. Overview

The Commonwealth of Massachusetts has developed a housing strategy which will achieve a supply of qualified residencies so that each MFP eligible individual or their representative can choose a qualified residence prior to transition.

Massachusetts is a state with high housing costs. Priced Out 2008 (TAC) found that the percentage of SSI needed to rent a one bedroom apartment in 2008 was 131.5%, significantly above the national average of 112.1%. With 49,000 state-funded public housing units and over $35 million in state funded rental assistance programs, the commonwealth has worked hard to create a pool of affordable housing for its citizens including people with disabilities. Despite these efforts, additional resources are needed to make a supply of affordable qualified residences available. The following outlines the steps the commonwealth proposes to take to create this pool.

II. Inventories and Needs Assessments

The Commonwealth of Massachusetts has a number of inventories and needs assessments that are available to assist consumers and their advocates to identify qualified residences.

A. Inventories that help find housing

MassAccess: The Massachusetts Accessible Housing Registry is a free web based program that tracks vacancies of affordable and accessible apartments for people with disabilities and elders. Established with a demonstration grant from HUD, this is one of the first inventories of accessible housing in the country. Massachusetts law requires that owners of any accessible units list vacancies with MassAccess; there is no cost to the owner for the listing. MassAccess can be viewed at www.MassAccessHousingRegistry.org. Some screen shots are provided in Appendix H. In 2010, MassAccess listed 455 vacant accessible units and received over 2,369,412 "hits".

One component of the commonwealth's MFP Demonstration proposal includes enhancements to MassAccess. These enhancements will:

- Improve the functionality to conduct housing searches for specific groups including elderly only and family;
- Improve functionality for sorting developments with open wait lists versus developments with current vacancies;
- Conduct complete review of the entire site for updates/upgrades with current web technology (current site is now two years old);
- Update the Help and Resource Section of the Registry including fact sheets on housing search, reasonable accommodations and fair housing laws; and
- Provide support for ongoing training for property managers and end users.

MassHousing: MassHousing is the state's Housing Finance Agency. The agency oversees over 100,000 units of rental housing including hundreds of units of accessible housing across the commonwealth. One of the ways the agency assists those seeking affordable housing is through an on-line inventory of all of the housing under their purview. The inventory can be viewed at https://www.masshousing.com/portal/server.pt/gateway/PTARGS_0_2_1143_0_0_18/HousingList_Full.pdf . A sample page from the inventory is provided in Appendix I.

PHA inventory: Of the 351 cities and towns in Massachusetts, 251 have Public Housing Authorities (PHAs). These PHAs have very varied portfolios, from PHAs with a single small elderly/disabled state-funded housing development to large urban housing authorities with thousands of PHA-owned units as well as large state- and federally-funded rental assistance programs. The commonwealth maintains an inventory of the housing stock of each of these PHAs, including the over 49,000 state funded and 44,000 federally funded public housing units and 80,000 rental vouchers. This inventory allows a household seeking housing to target their search, e.g. not applying at a housing authority which has no mobile rental assistance if that is their housing goal. Combined with the states' on-line handbook which provides contact information for these PHAs and on-line universal housing application, housing search is greatly facilitated. See www.mass.gov/dhcd.

Mapping Project: Finalized in June 2010, the goal of the Mapping Project was to collect data about permanent housing units either funded in part by the following five EOHHS agencies or targeted for use by the consumers served by these agencies:

- Department of Developmental Services (DDS)
- Department of Mental Health (DMH)
- Department of Public Health, HIV/AIDS and Substance Abuse Bureaus (DPH)

- Executive Office of Elder Affairs (EOEA)
- Massachusetts Rehabilitation Commission (MRC)

The final report includes an inventory of housing resources developed by/for these agencies by city and town in Massachusetts. While the inventories listed above primarily capture affordable and accessible rental housing, the Mapping Project includes housing resources such as small group homes which are also qualified residences and potential choices for MFP participants.

Housing Assessment Tool: The Systems Transformation Grant (STG) Housing Assessment Tool is a resource for housing search specialists and persons with disabilities and elders searching for housing in Massachusetts. The tool can prepare the consumer to complete housing applications and help identify housing needs. The STG Team also developed a complementary STG document entitled "Housing Search Guide for People with Disabilities and Elders: Resources." The Guide is a compilation of resource lists and glossaries to assist consumers and their advocates in housing search.

B. Assessments of Needs

In developing this Housing strategy, the commonwealth drew on a number of studies looking at the housing needs of people with disabilities living in Massachusetts facilities. These include:

Mapping Project: The Mapping Project Report (June 2010) uses a combination of data from interviews with staff from state agencies and statistical data such as the U.S. Census to determine the housing needs of some of the MFP target populations.

MFP Needs Assessment: A needs assessment was conducted by the core planning group for this application. The group included high level staff from agencies serving persons eligible

for MFP including the Department of Developmental Services, Department of Mental Health and the Massachusetts Rehabilitation Commission as well as EOHHS and MassHealth. These agencies conducted surveys of their programs to first identify persons eligible for MFP, and within this group, those who would be interested in moving into a qualified residence. This resulted in the target number of persons to be served by this proposal.

III. Addressing Housing Shortages

Since the early 1980s, the Commonwealth of Massachusetts has demonstrated a commitment to the development of affordable housing including housing for people with disabilities. In 1976, the state legislature established a state bond program, the Chapter 689 program, to provide funds to Local Housing Authorities for the development of housing for people with disabilities including group homes and accessible housing. In 1993, the commonwealth developed another state funded bond program specifically to develop housing for people leaving state schools and state hospitals; in 2004, similar legislation was created to serve elders and persons with other disabilities leaving nursing facilities. In 1990, the state legislature created a state-funded rental assistance program for people with disabilities, the Alternative Housing Voucher Program (AHVP).

Despite this significant investment of state funds in housing for people with disabilities, there is still a shortage of affordable, accessible housing in this expensive housing market. The following outlines how the commonwealth proposes to address this shortage and ensure there is housing supply that is adequate to provide choice for MFP Demonstration program participants.

A. MFP Stakeholders Working with Housing Agencies

MassHealth, EOHHS and its agencies will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet the housing needs of

MFP participants. The Massachusetts MFP proposal will draw on collaborations already in place between MassHousing (the state's Housing Finance Agency), the Department of Housing and Community Development (DHCD), the state-level housing agency and local housing authorities including:

- The EOHHS Housing Working Group, which includes staff from the housing agencies as well the state human services agencies. The Working Group meets regularly, every 4-6 weeks, to problem solve, develop policies and procedures and maximize use of existing housing resources.
- EOHHS collaborated with DHCD as well as 5 local housing authorities to apply for Category 2 Non-elderly Section 8 Vouchers. These collaborations resulted in total requests of upwards of 215 vouchers which can be targeted to MFP participants if awarded;
- Collaboration on selection of housing units funded under the Community-Based Housing (CBH) and Facilities Consolidation Fund (FCF) Programs and extensive training for DHCD architects regarding accessibility requirements.; and
- Collaboration on development and administration of the Home Modification Loan Program (HMLP).

The MFP Demonstration program will build on these relationships to expand programs that can increase the availability of qualified residences. Opportunities that these collaborations offer and which the project will pursue include:

MassHousing Set-Aside Program: Since 1978, as a condition of financing, MassHousing has required developers to set-aside 3% of rental housing units for clients of the Departments of Developmental Services and/or the Department of Mental Health. This policy has resulted in the

development of over 500 units. MFP will work with MassHousing to enhance this opportunity in several ways. First, not all of the set-aside units are affordable. The "Affordability" Section of this housing strategy below describes some resources that the project will seek to ensure all of these units are affordable to very-low-income persons. Second, MFP will seek a preference for applicants who are coming from institutions to ensure that MFP participants are at the top of the list for these units.

Supportive Housing Program: The Supportive Housing Initiative was developed by the Executive Office of Elder Affairs and DHCD to assist individuals living independently in their own apartments in state funded public elderly/disabled housing. Supportive Housing employs resident service coordinators to assist residents in accessing needed LTSS funded by the Executive Office of Elder Affairs or other public payers. This program was first implemented on a pilot basis in 1999 at three elder housing developments. It has since been expanded to 31 locations. By pooling resources that are currently being invested in an existing development by an ASAP and a housing authority, frail, low-income elders as well as younger people with disabilities have an opportunity to access a model of affordable supportive housing that promotes independence as well as "aging in place". Services are offered to eligible individuals on an as needed basis, 24 hours per day. Residents who do not qualify for state funded home care services based on their frailty level and income are able to privately purchase the entire package of supportive services or some of the services based upon their need. Residents who are home care eligible receive all or some of the services at no additional cost.

Community Based Housing Program (CBH): The CBH Program provides funding for the development of integrated housing for people with disabilities, including elders, with priority for individuals who are in institutions or nursing facilities or at risk of institutionalization. CBH

prioritizes projects that provide integrated housing such as several CBH units within a larger rental building or development, with no more than 15% of the total units for people with disabilities. The CBH Program does not require all units to be fully accessible but strongly encourages accessibility through visitability.[22] MRC has issued a design guide to help developers make their projects eligible for CBH funds by making them more visitable and functional for people with disabilities. The guide, *Access and Function in Affordable Housing in Massachusetts*, aims to assist developers and architects in achieving full compliance with all requirements for accessible design and simultaneously enhancing their developments with universal design features for residents and visitors. The guide consists of two parts: *Part One - A Developer's Overview* - provides an overview of the civil rights laws which require accessibility, which accessible design standards are triggered by various affordable housing programs, and how to make housing for people with disabilities more usable; *Part Two-An Architect's Tool* - provides a detailed comparison of the state and federal accessible design requirements and specific design suggestions for enhancing a development's usability by people of all ages and abilities. These guides are available on-line at http://cedac.org/pdf/DevelopersDesignOverview.pdf and http://cedac.org/pdf/AchievingAccessII.pdf

Since its inception in 2004, CBH has funded 186 units with another 60 waiting for funding. The program is currently allotted $5 million in state bond funds annually. The MFP Demonstration will seek to use this valuable housing program to increase housing for the target

[22] A home is visitable when it meets three basic requirements: 1) one zero-step entrance at the front, back or side of the house; 2) all main floor doors, including bathrooms, with at least 32 inches of clear passage space; and 3) at least a half bath, preferably a full bath, on the main floor that is wheelchair accessible. See www.concretechange.org.

population in two ways: (1) MFP will work with DHCD to seek a higher bond cap for all DHCD housing programs, including CBH, and (2) MFP will work with MRC and DHCD to better ensure the target populations secure these qualified residences.

Facilities Consolidation Fund (FCF): Like CBH, FCF is a program funded with state bond funds targeting the creation and retention of community-based housing for the consumers of services of DDS and DMH. FCF has been an invaluable resource for DDS and DMH in moving consumers from institutional living to community-based housing. Since its inception in 1993, FCF commitments totaling $92.8 million have funded over 2,416 units. DHCD's FY2009 capital budget included $7.5 million for FCF, increased from $6.0 million in FY2008, but level-funded in 2010. DDS and DMH have utilized FCF with significant success in differing housing models. DDS has used FCF to build a large number of community-based group residences, primarily housing between 4 and 8 residents. For DMH clients, a significant portion of FCF has supported the development of units integrated within larger developments. FCF is currently fully committed through 2013. The MFP Program will seek to increase the resources available under FCF by working with DHCD to increase the bond funds allocated to all of its housing programs. Unlike CBH, not all have project based rental assistance. MFP will seek to identify resources to enhance the affordability of these qualified residences.

Rural Housing Service (RHS) Section 515 Housing: In Massachusetts, the bulk of the Section 515 units are in elderly-only developments. Most projects have some form of project-based rental assistance (Section 8 or RHS rent subsidies; a few have state-funded rental assistance under the Massachusetts Rental Voucher Program (MRVP)). Massachusetts has 43 RHS-funded developments for the elderly in Massachusetts with 1,481 affordable units. The

Statewide Housing Coordinator will work with the regional RHS office and the funded developments to identify opportunities for MFP participants.

B. State Strategies to Promote Availability, Affordability and Accessibility of Housing

One of the state strategies to promote availability, affordability and accessibility of housing for people transitioning from nursing facilities and institutions in Massachusetts is the establishment of a Statewide Housing Coordinator at the Executive Office of Health and Human Services, within the Office of Medicaid. This position will be key to establishing and maintaining linkages at the state and regional levels between human services and housing entities. The Coordinator will oversee implementation of this housing action plan including coordination of regional housing activities and ensure the needed number of affordable and accessible qualified residence units will be made available to those transitioning.

1. Accessibility

Multiple forums, including the state's Systems Transformation Grant's Housing Committee, have identified housing accessibility as a distinct priority that must be addressed in order to succeed in transitioning individuals from facilities. In addition to the MassAccess Program described above, the Massachusetts MFP Demonstration program will enhance access to accessible qualified residences in several ways.

Home Modification Loan Program: The state-funded Home Modification Loan Program (HMLP) provides loans to make access modifications to the primary, permanent residence of elders, adults with disabilities, and families with children with disabilities. Such modifications allow people to return home from institutions. Households with incomes up to 100% of median income are eligible for 0% interest rate, deferred payment loans. There are six agencies

throughout the state that administer the program for MRC. The program lends money to homeowners who wish to start new modification projects, but does not reimburse for work that has been already completed. Any homeowner who has a disability, has a household member with a disability, or rents to an individual with a disability may apply for this loan. The owner of the residence must apply for the loan.[23] In 2010, 188 HMLP loans were made. The program currently has access to $4 million in state bond funds annually. As part of this proposal, the MFP Demonstration program will request the state to prioritize persons coming from institutions for these loans. Such a preference will better allow homeowners – including many elders – to return to their own homes from institutions.

Universal Design: The state's housing agency has indicated some willingness to commit to creating housing that is designed to be universally accessible. For example, the Qualified Allocation Plan (QAP) requires that developments which incorporate certain aspects of universal design receive higher scores in the competition for tax credits. DHCD has been working with MRC to ensure its architects have been trained in access code and universal design. The MFP Demonstration program will explore the expansion of Universal Design in other programs administered by DHCD, including HOME, CDBG, Public Housing and the state funded bond programs such as FCF.

2. Availability

As described above, even with the housing resources the state has available, a shortage remains. The commonwealth will address this shortage of affordable housing with the following strategies to help MFP participants access qualified residences in the community.

[23] Some landlords may be eligible for a 3% loan for a tenant with a disability.

Qualified Allocation Plan (QAP): The commonwealth has incorporated some disability-friendly policies in the QAP. For example, evidence of DHCD's commitment to universal design is evident in the commonwealth's QAP. The document requires that developments which incorporate certain aspects of universal design receive higher scores in the competition for tax credits. However, if the market for tax credits strengthens over the five years of the demonstration program, the QAP could potentially target units to persons leaving institutions, or like the State of Pennsylvania, require developers to provide units at 20% of Area Median Income (AMI) – a level that is more affordable to the target population. The Massachusetts's MFP Demonstration program will explore these options over the period of the program.

Regional Resources: The most recent Consolidated Plan for the commonwealth estimates there are 193,000 rental units in Massachusetts supported with public assistance, twice the national average. Although the commonwealth operates several large statewide rental assistance programs, the majority of these rental assistance resources are administered by nine regional entities, 254 Public Housing Authorities and hundreds of nonprofit agencies. MFP hopes to access these resources for the targeted individuals. To accomplish this goal, Massachusetts MFP will hire five regional housing coordinators. These housing coordinators will collaborate with the commonwealth's 11 ADRCs, nine Regional Housing Non Profits, local PHAs, state agency regional housing staff, local providers, housing search entities, advocates and others. The housing coordinators will meet monthly to discuss available resources, and will assist case managers in identifying resources, such as underutilized public housing, to meet the housing needs of the MFP participants in their region.

Housing Search Assistance: To complement this regional effort, the MFP Demonstration program will contract with a range of entities to assist individuals with housing search. The case

managers (see Section B.1 above) will be responsible for working with individuals to educate them as needed about housing options and assist them in determining their preferred option(s). Once the individual indicates their preference, one of the housing search entities will be enlisted to assist. These entities can include ILCs, ADRCs, homeless housing search agencies, even realtors. The type of entity under contract for this service will differ across the regions. Their responsibility will be to help the consumer identify housing, ensure housing applications are obtained and completed (with case manager), assist in collection of any required documentation, and support submission of this documentation.

3. Affordability

As described above, Massachusetts is a state with high housing costs. Priced Out 2008 (Technical Assistance Collaborative, Inc.) found that the percentage of SSI needed to rent a 1 BR in 2008 was 131.5%, significantly above the national average of 112.1%. Qualified residences must be affordable.

Housing Choice Voucher Program (HCV): DHCD administers a HCV program with an estimated 19,000 units. The agency has very aggressively pursued all opportunities to secure HCVs targeted to people with disabilities; the agency has secured 600 "Certain Development" HCVs, 275 Mainstream HCVs, 29 Fair Share Medicaid HCVs and 145 Fair Share People with Disabilities HCVs. DHCD worked with EOHHS to make an application for Category 2 Nonelderly Vouchers and will hopefully receive an award of funds in 2011. DHCD already provides a preference for persons living in institutions under its Section 8 Program. MFP will work with DHCD to ensure MFP participants can apply to the program, are assigned the preference and have equal access to these resources.

Alternative Housing Voucher Program (AHVP): The commonwealth funds this rental assistance program for which only persons with disabilities are eligible. State guidelines require this program provide a preference for persons leaving institutions. MFP will work with DHCD to ensure MFP participants have an opportunity to apply to the program and are assured this preference. MFP will also work to increase the program's funding level.

Project-Based Vouchers (PBV): DHCD has allocated a portion of PBV to ensure units developed through the CBH Program are affordable housing targeted to very-low-income persons with disabilities, at 30% of their income. The MFP Project Director will work with DHCD to ensure this model program continues as resources permit.

10. Continuity of Care Post the Demonstration

Describe how the following waiver provisions or SPAs will be utilized to promote effective outcomes from the Demonstration and ensure continuity of care: Managed Care/Freedom of Choice: 1915(b); HCBS Waiver: 1915(c); 1115 Research and Demonstration; State Plan – provide evidence of certain things for each (reserved slots, caps, new waivers).

a. Managed Care/Freedom of Choice (section 1915b) – for participants eligible for managed care/freedom of choice services, provides evidence that:
    i. 1915b waivers and managed care contracts are amended to include the necessary services
    ii. Appropriate HCBS are ensured for eligible participants; or
    iii. A new waiver will be created.

Massachusetts does not currently operate 1915(b) waivers, nor will the state utilize such mechanisms for purposes of the MFP demonstration.

b. Home and Community Based (section 1915c) - for participants eligible for "qualified home and community-based program" services, provides evidence that:
    i. Capacity is available under the cap;
    ii. A new waiver will be created; or
    iii. There is a mechanism to reserve a specified capacity for people via an amendment to the current 1915c waiver.

Massachusetts strategy to promote effective outcomes from the MFP Demonstration and to ensure continuity of care is based largely on the use of HCBS waivers and our rich array of optional state plan LTSS. Massachusetts currently operates multiple HCBS waivers for various populations. Many of these existing waivers have goals that are consistent with those of the MFP Demonstration program and will be available broadly to individuals identified as MFP qualified who transition from facilities into the community. In addition, Massachusetts is developing, specifically for MFP qualified participants, two HCBS waivers to supplement existing waivers in order to provide HCBS for individuals who have transitioned, as well as to ensure continuity of care post the demonstration.

The table below shows both existing and new waivers that Massachusetts anticipates will provide HCBS to MFP qualified participants both during and post the demonstration period. Massachusetts will propose two new waivers to ensure provision of HCBS and continuity of care for MFP qualified individuals. Specifically, Massachusetts will apply for two HCBS waivers: the MFP Residential Supports waiver and the MFP Community Living Waiver. In addition, each of the existing HCBS waivers shown in the table below will accommodate MFP qualified individuals. In any case for which an existing HCBS waiver may include provisions that do not precisely fit a given MFP qualified individual who is in need of waiver services, the state will have available one of the new HCBS waivers it is proposing. For example, for an individual who does not meet the exact clinical eligibility requirements for one of the ABI waivers, which specify, for example, that applicants be 22 years old or older, one of the MFP waivers would be utilized. Similarly, for an individual who does not meet the age or diagnosis-specific eligibility

requirements for an existing waiver, one of the MFP HCBS waivers would provide the necessary home and community-based services as well as ensure continuity of care post the demonstration.

Waiver	New/Existing	Population Served	Status
Frail Elder	existing	Elders, 60 and older	Capacity available under the cap
DDS Residential Supports	existing	Intellectual Disabilities, 18 and older	Capacity reserved for transitioning individuals
DDS Community Living	existing	Intellectual Disabilities, 18 and older	Capacity reserved for transitioning individuals
Acquired Brain Injury – Residential	existing	Brain Injured, 22 and older	Capacity available under the cap/to be supplemented with new MFP waivers
Acquired Brain Injury – Non residential	existing	Brain Injured, 22 and older	Capacity available under the cap/to be supplemented with new MFP waivers
MFP Residential Supports	new	Adults 18 and older (disabled if under 65)	New waiver under development
MFP Community Living	new	Adults 18 and older (disabled if under 65)	New waiver under development

Massachusetts will make optimal use of our existing HCBS waivers to provide HCBS to and ensure continuity of care for MFP qualified individuals, but will also develop and implement two new HCBS waivers in order to promote effective outcomes from the demonstration and to ensure continuity of care post the demonstration period.

c. Research and Demonstration (sec 1115) – for participants eligible for research and demonstration waiver services, provides evidence that:
   i. Slots are available under the cap;
   ii. A new waiver will be created; or
   iii. There is a mechanism to reserve a specified number of slots via an amendment to the current 1115 waiver.

Massachusetts currently operates a large scale acute and primary care 1115 demonstration waiver. This managed care waiver serves all MassHealth members, with the current exception of those who are dually eligible. The 1115 waiver allows for the provision of home and community based state plan and waiver services, although does not incorporate these services into its managed care products. Rather, members have access to these optional services and HCBS waivers as fee for service (FFS) benefits. The Primary Care Clinician (PCC) and Managed Care Organization (MCO) plans have been providing high-quality care for years to much of MassHealth's complex, disabled membership. Massachusetts 1115 managed care waiver is not capped; enrollment is 1.2 million members at present. Given that this waiver is the primary vehicle through which many MFP qualified members have enrolled or will enroll in MassHealth, the route to gaining eligibility is well established and consistently applied. All members eligible for MassHealth will have access to any needed state plan services, and any member who gains eligibility for MassHealth through a HCBS waiver will also be eligible for MassHealth, either through the Managed Care 1115 waiver or as a fee for service member.

The Massachusetts 1115 waiver is the basis of MassHealth membership for the vast majority of the state's Medicaid eligible population, and this will be the case within and after the MFP demonstration. Any member who otherwise fits the categorical eligibility requirements will receive his or her MassHealth benefits either through the 1115 waiver, or through a fee for service mechanism. In either case, the specifics of the MFP demonstration will not change how such members access MassHealth. Since the 1115 waiver is not capped, this vehicle is available to any MFP qualified members who otherwise meet the 1115 waiver requirements.

d. State Plan and Plan Amendments – for participants eligible for the State plan optional HCBS services, provide evidence that there is a mechanism where there would be no

disruption of services when transitioning eligible participants from the demonstration program.

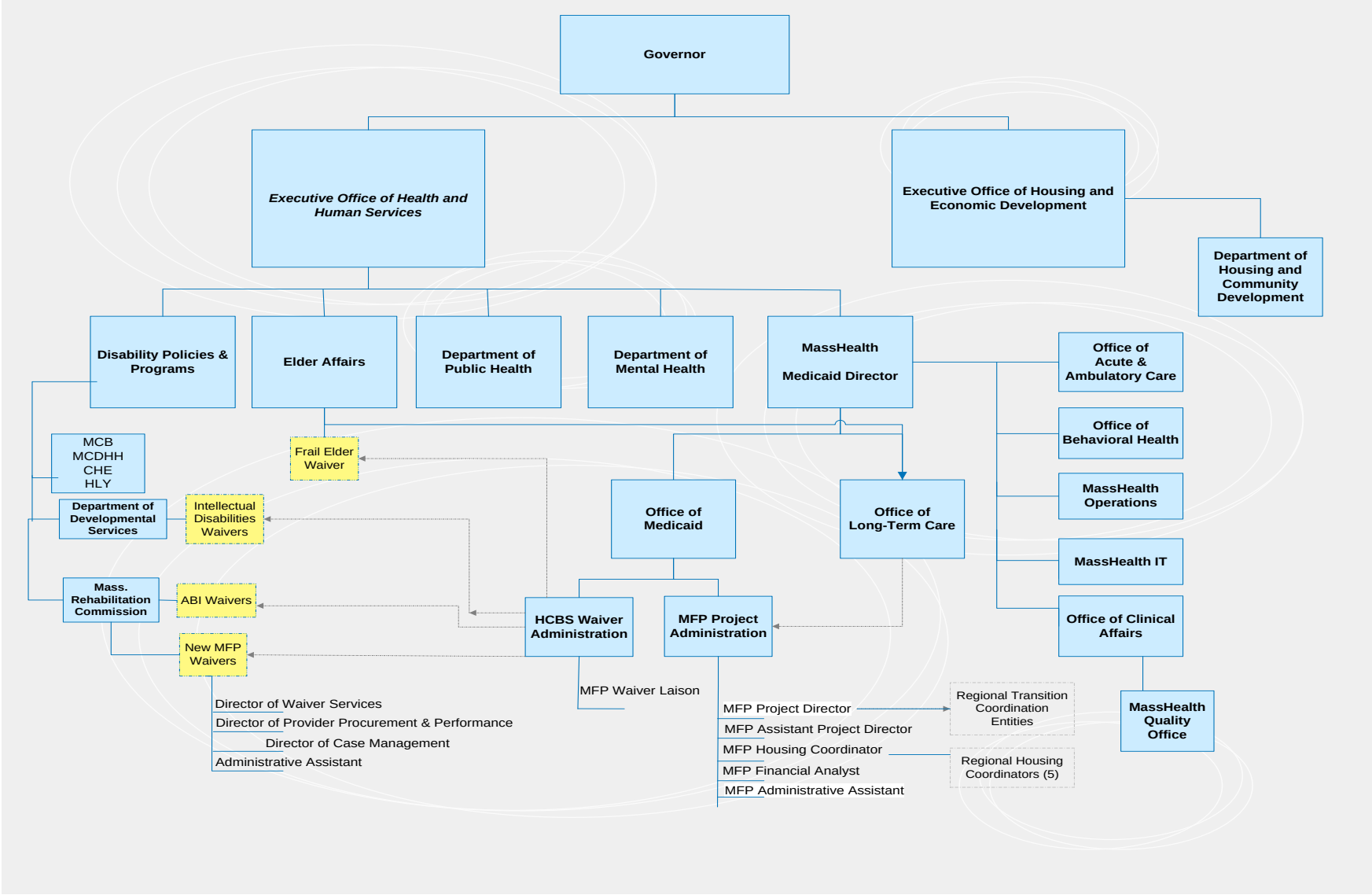
The Massachusetts State Plan currently provides multiple optional home and community based services to MassHealth eligible members, including: Personal Care Attendant, Adult Day Health, Durable Medical Equipment, Adult Foster Care, Group Adult Foster Care, and many others. As MFP qualified persons are identified and assisted to transition from facilities, they will utilize State plan services to the extent they are needed and desired, either solely or in combination with a HCBS waiver program to obtain needed HCBS and to fully support their ability to maintain their tenure in the community. At the end of the demonstration, these services will remain a key component of the state's ability to promote effective outcomes from the demonstration and to ensure continuity of care.

C. Organization and Administration

1. Organizational Structure

Provide an organizational chart that describes the entity that is responsible for the day to day management of this grant and how that entity relates to all other departments, agencies and service systems that will provide care and supports and have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.

See MFP Organizational Chart on page 80


Governor
Executive Office of Health and Human Services
Executive Office of Housing and Economic Development
Department of Housing and Community Development
Disability Policies & Programs
Elder Affairs
Department of Public Health
Department of Mental Health
MassHealth
Medicaid Director
Office of Acute & Ambulatory Care
Office of Behavioral Health
MassHealth Operations
MassHealth IT
Office of Clinical Affairs
MassHealth Quality Office
MCB
MCDHH
CHE
HLY
Frail Elder Waiver
Department of Developmental Services
Intellectual Disabilities Waivers
Office of Medicaid
Office of Long-Term Care
Mass. Rehabilitation Commission
ABI Waivers
HCBS Waiver Administration
MFP Project Administration
New MFP Waivers
MFP Waiver Laison
Director of Waiver Services
Director of Provider Procurement & Performance
Director of Case Management
Administrative Assistant
MFP Project Director
MFP Assistant Project Director
MFP Housing Coordinator
MFP Financial Analyst
MFP Administrative Assistant
Regional Transition Coordination Entities
Regional Housing Coordinators (5)

2. Staffing Plan

Provide a staffing plan that includes: written assurance of FTE Project Director; # and title of dedicated positions paid for by grant and justification of need; % of time each individual/position is dedicated to grant; brief description of role/responsibilities; positions providing in-kind support; # of contracted individuals; detailed staffing timeline; entity responsible for performance assessments of staff involved.

The organizational chart provided illustrates that the commonwealth is prepared to leverage all its relevant agencies and offices to support implementation and ensure the success of the MFP Demonstration. Direct MFP administration will be housed in the Office of Medicaid, the administrative unit of the MassHealth program, where all MFP activities will be directly accountable to the Medicaid Director through his designee, the Director of Member Policy and Program Development. This organization structure is designed to create maximum accountability and coordination for the purposes of federal reporting, program integrity, contracting, systems and program development benchmarking, and financial management.

MassHealth Office of Medicaid will immediately post and hire for the positions of MFP Project Director and Assistant Project Director. Both will be senior management-level positions, dedicated 100% to the MFP Demonstration. The Project Director will report directly to the Director of Member Policy and Program Development. This person will have experience in providing services and developing programs to support independent living for persons with disabilities and/or elders and have a demonstrated ability to manage complex projects requiring extensive coordination among public, private, and not-for-profit entities. In addition, the Project Director will facilitate maximum stakeholder engagement throughout the demonstration to ensure that MFP implementation has the benefit of the wealth of knowledge available through

MassHealth members, state agencies, ASAPs, ILCs, ADRCs, RLCs, disability-and elder-serving advocates, providers, academics, clinicians, legislators, as well as state and local housing entities. The Project director will be responsible for developing the overall project plan and ensuring that timelines and milestones are achieved, and will develop communications, transition and quality plans and accept and respond to complaints related to the MFP project. Further, this person will be the key contact with the CMS Project officer and ensure that Massachusetts conforms to all compliance activities required by CMS. The job description for this position is provided in Appendix J. The target date for filling the position of Project Director will be February 11, 2011.

The Assistant Project Director will report to the MFP Project Director. This position will focus on coordination of key operational requirements for the MFP Demonstration. Under the direction of the Project director, the responsibilities of this position include, but are not limited to: developing and communicating MFP business specifications for Information Technology programming; coordinating procurement activities; managing relationships among agency contact persons regarding MFP; assembling reports; managing the development and production of MFP marketing and informational materials; convening trainings, and developing operational procedures. The target date for filling the position of Assistant Project Director will be March 11, 2011, allowing the Project Director to be involved in the selection process.

The following additional positions reflect the building of significant infrastructure to enhance community-based options in the MassHealth program and will be part of the new MFP Project Administration Unit under the leadership of the MFP Project Director in the Office of Medicaid:

MFP Housing Coordinator: This position will be key to establishing and maintaining linkages at the state and regional levels between human services and housing entities. The

Housing Coordinator will oversee development and implementation of the housing action plan including oversight of contracted regional housing coordinators and coordination of regional housing activities and ensure the needed number of affordable and accessible qualified residence units will be made available to those transitioning. This position will be 100% dedicated to the MFP Demonstration. The target date for filling the Housing Coordinator position will be April 15, 2011.

MFP Financial Analyst: This position will be responsible for ensuring that MassHealth has the systems and reporting protocols in place to both accurately reflect MFP spending and account for the demonstration of rebalancing of MassHealth long-term care expenditures. The financial analyst duties include, but are not limited to: providing business specifications for the coding of the MassHealth eligibility system, MMIS, and data warehouse to ensure MFP participants, services and expenditures are accurately reported; preparing MFP budget reports: assigning appropriate federal enhanced matching rates to approved services; monitoring and tracking reinvestment of MFP enhancements into community-based long-term care services and infrastructure; tracking maintenance of effort, transition, and benchmark goals; representing MFP objectives in the state budgeting process. This position will be 100% dedicated to the MFP Demonstration. The target date for filling the Financial Analyst position will be April 15, 2011.

Administrative Assistant: This position will support all communications, reporting, secretarial and administrative support needs of the MFP Project Administration Unit. This position will be 100% dedicated to the MFP Demonstration. The target date for filling this position will be February 1, 2011.

MFP Waiver Liaison: This position will report to the Director of HCBS Waivers in the Office of Medicaid. As described earlier, MassHealth will apply for two new Home and

Community Based Waivers via 1915 (c) authority to provide community services to individuals in facilities who are part of populations not served by existing waivers. This is to ensure that all MFP-qualified persons will have an adequate set of services available when they return to the community. The Massachusetts Rehabilitation Commission (MRC) will be the operating agency for these new "MFP Waivers." As required, the Medicaid agency will be responsible for waiver oversight and for administrative functions associated with applying for, monitoring and reporting on the new waivers. The MFP Waiver Liaison will perform these Medicaid functions for the new MFP waivers as well as track MFP participants in the existing HCBS waivers, validate expenditures, reconcile MFP and CMS-372 reporting, and evaluate the adequacy of total slot capacity across all HCBS waivers and appropriateness and availability of waiver services for MFP participants. This position will serve as a liaison between the MFP program and ongoing HCBS waiver management to promote evolution of MassHealth community-based services options. This position will be 100% dedicated to the MFP Demonstration. The target date for filling this position will be April 15, 2011.

The following MFP positions will be managed by MRC to support their operational responsibilities for MFP participants who will enroll in the new MFP waivers:

Director of MFP Waiver Services: This position will report to the MRC Deputy Commissioner. Duties will include, but not be limited to: liaison with OOM, and other MFP Demonstration staff for the purpose of oversight of all MFP Demonstration grant and related HCBS waiver activities; supervision of the Director of Provider Performance and Director of Case Management and Transition Services; interface with MRC 's ABI & TBI Waiver Units for the purposes of coordination of waiver activities, liaison to MFP transition services and securing appropriate placements for participants in the new MFP Residential Supports waiver;

coordination with and monitoring of MFP waiver case management activities, interface with MRC's Business Office for all MRC procurements related to the MFP Demonstration and the related HCBS Waivers; interface with the Director of Research and Performance Management and assigned staff for all data tracking and quality management reporting. Responsibilities include quality management and quality improvement activities in order to ensure the provision of person-centeredness and self direction of services as well as participant satisfaction with services. This position will be 100% dedicated to the MFP Demonstration. The target date for filling this position will be September 16, 2011.

Director of Provider Procurement & Performance: This position will be responsible for overseeing the procurement of, home accessibility contractors, and residential services options for MFP participants and ensuring provider compliance with the specified operational performance requirements related to the fulfillment of participant-centered outcomes, person-centeredness and self direction of services, as well as to health and safety requirements, ongoing monitoring of provider adherence to contracting specifications, and MRC MFP Waiver policies and procedures. Through a Continuous Quality Improvement (CQI) management approach, this position will support the development and oversight of a comprehensive network of community-based services providers through performance monitoring and the provision of technical assistance when necessary. This position will be 100% dedicated to the MFP Demonstration. The target date for filling this position will be September 16, 2011.

Director of Case Management: This position will be responsible for oversight and representing MRC in the procurement of case management services for Residential & Community Support waivers as well as Demonstration case management offered for 365 days to MFP participants who choose not enroll in waivers; interface with the Director of Research and

Performance Management for all data tracking and quality management reporting; facilitation of the provision of training, technical assistance to the case management and transition services provider network; provision of case consultation as appropriate; oversight of an MFP waiver complaint management system and related investigations regarding case management services; interface with the MFP Housing Coordinator and others for the purpose of ensuring appropriate supports for participants in housing search; collaboration with the MFP Project Director regarding oversight of Information and Referral Services to facilitate consumer choice and self-direction. This position will be 100% dedicated to the MFP Demonstration. The target date for filling this position will be September 16, 2011.

Administrative Assistant: This position will support all communications, reporting, secretarial and administrative support needs of the MRC MFP Waiver Services Unit. This position will be 100% dedicated to the MFP Demonstration. The target date for filling this position will be September 16, 2011.

There are many other positions within the EOHHS that will providing in-kind support to the project but that are not directly paid for by the MFP Demonstration. These positions exist prior to the demonstration and are fully staffed. The positions providing support are outlined in the chart below.

Positions Providing In-Kind Support

Name	**Title**	**Roles and Responsibilities**
Corrinne Altman Moore	Director of Federal Financing	Financial forecasting and analysis; budget planning, development, tracking and reporting; needs analysis and input into MassHealth IT systems development, including data warehouse, MMIS, MA-21.

Amy Andrade	Director of Policy Implementation, MassHealth Eligibility Operations	Technical support for analysis, planning, development and implementation of MassHealth eligibility systems (MA-21) changes needed to support MFP demonstration.
Robin Callahan	Director of Member Policy and Program Development	Medicaid Director designee for MFP Demonstration oversight
Charles Carr	Commissioner, Massachusetts Rehabilitation Commission	Leadership for and direction of the operation of the MFP waivers; accountable for waiver implementation, oversight, monitoring and quality reporting
Terence Dougherty	EOHHS Assistant Secretary and Medicaid Director	Leadership and direction of the MassHealth Program; advocacy, leadership and promotion of the MFP demonstration within the Patrick Administration and externally with CMS, legislators, and stakeholders.
Rosalie Edes	Deputy Assistant Secretary, Disability Policy and Programs	Liaison for EOHHS Disability Policy and Programs between Office of Medicaid and MRC; leadership and technical support for MFP waiver implementation, development of required policies and procedures, and quality oversight.
Patricia Ford	Deputy Commissioner, Massachusetts Commission for the Deaf and Hard of Hearing	Liaison to MCDHH for planning, development and implementation issues related to MFP demonstration
Michele Goody	Director of Community Based Waiver Programs	Direct the development and implementation of the MFP waivers; primary interface with CMS; technical assistance and support to MRC staff in on-going waiver operation, quality monitoring and oversight; support needs analysis/input into MassHealth IT systems development.
Seth Haber	Lead Attorney, MassHealth Long Term Care	Provide Legal support; collaborate on, draft and secure legal support for any needed regulations, procedures, etc. related to the MFP demonstration.

Patricia Hart	Program Manager, Massachusetts Commission for the Blind	Liaison to MCB for planning, development and implementation issues related to MFP demonstration
Laurie Hutcheson	Assistant Commissioner, Department of Mental Health	Liaison to Department of Mental Health for planning, development and implementation issues related to MFP demonstration
Sharon Johnson	Director of MassHealth Publications	Support development and production of appropriate outreach and educational materials for MFP demonstration.
Ann Lawthers	Director of the MassHealth Quality Office	Coordinate with other efforts within the MassHealth agency to deliver quality services to MassHealth members.
Jean McGuire	Assistant Secretary, Disability Policy and Programs	Leadership and oversight of Department of Developmental Services and Massachusetts Rehabilitation Commission; leadership and direction on stakeholder collaboration and interaction.
Catherine Moriarity	Director of Compliance	Assist in development of efforts to identify fraud, waste and abuse in the Medicaid system; support development of an MFP program integrity plan; ensure consistency with overall compliance efforts.
Joe Quirk	Home Care Director, Executive Office of Elder Affairs	Direct efforts in support of MFP qualified participants within the Frail Elder Waiver and elder community service system;
Alda Rego	Budget Director, MassHealth	Provide direction, leadership and advocacy for budget development, funding acquisition and maintenance in support of MFP demonstration and rebalancing efforts.
Rachel Richards	Director of the MassHealth Office of Long Term Care and Assistant Secretary, Executive Office of Elder Affairs	Liaison between MassHealth and EOEA for MFP demonstration; leadership and support for MFP demonstration collaboration and coordination efforts with nursing facility industry, CSSM program, state plan community long term care services/programs, and frail elder waiver; supports development of required policies

		and procedures.
Eleanor Shea-Delaney	Assistant Commissioner, Department of Mental Health	Liaison to DMH planning transitions and post discharge HCBS; planning, development and implementation issues related to MFP demonstration
Greg Spino	Director, Data Warehouse	Support of MFP demonstration reporting through the EOHHS Data Warehouse
Larry Tummino	Assistant Commissioner, Department of Developmental Services	Liaison to Department of Developmental Services planning DDS transitions and post discharge HCBS; support for development of required policies and procedures, and quality oversight related to MFP demonstration.

3. Billing and Reimbursement Procedures

Describe procedures for insuring against duplication of payment for Demonstration and Medicaid program; and fraud control provisions and monitoring.

All new services offered under MFP will comply with MassHealth's existing guidelines to prevent duplication of services, fraud, and abuse. MassHealth plans to operate the MFP demonstration within current guidelines and procedures, and to monitor and pay for all new services through the MMIS claims system.

The MFP Project Director will collaborate with the EOHHS Director of Compliance to develop a program integrity plan for MFP. MFP will access the same fraud and abuse monitoring provisions as exist in the rest of the MassHealth program to ensure that qualified providers are delivering approved services to eligible members. MassHealth providers are required to disclose information about ownership and control, business transactions and criminal convictions. MassHealth utilizes this information to ensure that, prior to enrollment; all providers

are screened to identify excluded individuals or entities. In addition all providers are required to screen their employees using the OIG's List of Excluded Individuals/Entities.

MassHealth undertakes numerous efforts to combat fraud, waste and abuse and ensure that the limited funds available are spent wisely and appropriately. While efforts are taken throughout the program, two units primarily focus on preventing and detecting fraud: the MassHealth Operations Integrity Unit and the Provider Compliance Unit.

The MassHealth Operations Integrity Unit was created in June 2007, to integrate anti-fraud activities under one umbrella. This unit focuses on member fraud and manages the Provider Compliance Unit, further described below, which is operated by the University of Massachusetts Medical School under an ISA. The Operations Integrity Unit, among other things, researches all member fraud complaints and refers cases of suspected member fraud to the Bureau of Special Investigations (BSI.).

The Provider Compliance Unit (PCU) analyzes provider service utilization data to identify patterns of potential fraudulent, abusive, unnecessary or inappropriate utilization. PCU is responsible for administrative overpayment recovery projects as well as certain case reviews. PCU identifies duplicative, excessive or contraindicated care or services through data analysis and desk reviews of provider records. Data analysis is the cornerstone of the PCU's work. PCU also plays a key role in providing assistance and support to the Attorney General's Medicaid Fraud Division (MFD) in on-going fraud investigations.

MassHealth conducts numerous other activities to prevent and detect fraud. These include, among other things:

- Verifying eligibility information by matching or obtaining information from numerous federal and state agencies.
- Subjecting claims payments to a sophisticated series of edits.

- Operating Drug Utilization Review, Hospital Utilization Management, and Chronic Disease/Rehabilitation Hospital Utilization Management programs.
- Conducting clinical and financial audits.

D. Evaluation

Massachusetts is not pursuing additional evaluation of unique design elements of its MFP Demonstration program.

E. Final Budget

Unless otherwise noted, all administrative cost components have a 1% annual trend factor built in beginning in SFY13 (July 2012). Also, unless otherwise noted, the commonwealth requests 100% FMAP for all administrative costs.

Personnel

Massachusetts proposes the hiring of 10 direct FTEs and 5 contracted FTEs in order to implement and operate the MFP Demonstration and successfully execute all projected transitions to community settings. The commonwealth assumed the following regarding these positions, FTE counts, estimated start dates, and base salaries.

Ten positions will all be created to support the MFP Demonstration and to administer the two new MFP Home and Community Based Waivers:

i. MFP Project Director (1.0 FTE) – February 2011 ($90,000)
ii. MFP Assistant Project Director (1.0 FTE) - March 2011 ($75,000)
iii. MFP Housing Coordinator (1.0 FTE) – April 2011 ($70,000)
iv. MFP Financial Analyst (1.0 FTE) – April 2011 ($65,000)
v. MFP Waiver Liason (1.0 FTE) – April 2011 ($55,000)
vi. Administrative Assistant (1.0 FTE) – February 2011 ($50,000)
vii. Director of MFP Waiver Services (1.0 FTE) – April 2011 ($85,000)
viii. Director of Provider Procurement and Performance (1.0 FTE) – April 2011 ($70,000)
ix. Director of Transition Services and Case Management (1.0 FTE) – April 2011 ($70,000)
x. Administrative Assistant (1.0 FTE) – April 2011 ($45,000)

The five contracted positions are expected to be accountable to the Central Housing Coordinator at the Office of Medicaid:

xi. Regional Housing Coordinators (5.0 FTEs) – August 2011 ($60,000)

Fringe benefits

Massachusetts built in the rate of 31.82% for fringe costs related to the 10 direct and 5 contracted FTEs detailed in a) Personnel. (Note that fringe is not paid for the type of contracted positions Massachusetts is planning for the Regional Housing Coordinators, but this is costed out as it may be a cost component of the contract.) The fringe rate, which includes health insurance (25.36%), retirement (5.28%), and terminal leave (1.18%) is the Approved FY2011 Fringe Benefit amount set by the Comptroller of the commonwealth on July 12, 2010. The Comptroller separately calculates a payroll tax rate for each year, which the commonwealth has separately built into the MFP Administrative budget for these 15 positions. For FY11, this amount is 1.91%, and consists of Unemployment (0.37%), Universal Health (0.07%), and the Medicare Tax (1.47%).

Contractual costs, including consultant contracts (spell out if more than $10K)

Contracted Administrative Support. MassHealth plans to continue contracting with the University of Massachusetts Medical School for support with implementation and ongoing operation. OOM staff, including the MFP staff, would oversee this contract. The initial costs for implementation are assumed to occur through December 2011; ongoing operational costs are assumed to begin July 2011 and run through the duration of the Demonstration. Contracted functions and their respective costs for implementation and ongoing operations are as follows:

i. Project Management ($800,000/$200,000)
ii. Consumer Engagement Process ($200,000/$100,000)

iii. Provider Recruitment ($200,000/$100,000)

Contracted Local Housing Searches. The commonwealth expects that a housing search will need to be conducted for MFP Demonstration participants who are able to live independently and don't require the Residential Habilitation service. The administrative budget assumes a unit cost of $625 per housing search per non-Residential Habilitation MFP participant.

MFP 24-Hour Back-up System. The commonwealth plans to build in the cost of having 24-7 on-call capabilities into the case management services that will be procured for MFP Demonstration participants going into one of the two new MFP Home and Community-Based Waivers, or who can be supported in the community with State Plan services. Many of the individuals Massachusetts expects to be MFP eligible will be able to transition into one of the commonwealth's existing Home and Community-Based Waivers and may already have 24-7 on-call capabilities through their HCBW's case management, but the commonwealth's two ABI HCBWs do not have this capability. Participants in these waivers will also be able to access 24-7 on-call back-up support through the new case management services that will be procured for MFP. The cost built into the administrative budget is $7.50/MFP participant/month for their first 365 days post-transition.

Contracted Regional Transition Coordinators. Massachusetts plans to issue a procurement for 5 Regional Transition Coordinators. These contracts are assumed to cost $120,000 each.

Indirect charges, by federal regulation

The Executive Office of Health and Human Services (EOHHS) is a State Public Assistance Agency as defined by Appendix D in OMB Circular A-87, "Cost Principles for State,

Local, and Indian Tribal Governments*"* as codified in Title 2 of the *Code of Federal Regulations,* Part 225.

As is required by regulation, EOHHS continually updates, submits, negotiates and receives approval of its public assistance cost allocation plan from the U.S. Department of Health and Human Services. The use of a cost allocation plan in lieu of establishing an indirect cost rate is permitted in Appendix F 3 of the regulations.

On a quarterly basis, EOHHS identifies the actual indirect costs spent on behalf of each federal and state program by implementing the approved public assistance cost allocation plan. Those actual amounts of allowable administrative costs are then billed to programs upon identification.

This practice of billing an actual allowable amount quarterly would appear to be preferable to a granting agency rather than being billed an annual provisional indirect cost rate that must be adjusted to actual after the fiscal year. While the exact amount of indirect cost cannot be estimated, EOHHS is committed to accomplishing the goals of the award within the total grant cost proposed.

Travel

The commonwealth assumed annual travel costs of $1,500 per person for 4 OOM staff to attend regional and out of state conferences, training sessions, and meetings with CMS officials – MFP funds would only be used if the purpose of the travel is germane to the MFP Demonstration. The commonwealth also assumed mileage reimbursement for 5 OOM and MRC MFP staff ($3,000 annually each) and for the 5 contracted regional housing coordinators ($12,000 annually each). The commonwealth's current mileage reimbursement rate is $0.40/mile

– this works out to 625 miles/month for each of the OOM/MRC MFP staff (for site visits, trainings, and meetings), and 2,500 miles/month for each of the regional housing coordinators (pursuant to the execution of their contracted duties). Estimates were based on the travel projections for similar positions in another state agency.

Supplies

The commonwealth built in $1,000 annually for each of the requested 10 direct FTEs. The commonwealth also plans to include $4,000 for supplies for each of the five Contracted Regional Housing Coordinators in their contract agreements.

Equipment (front load – explain assumptions)

Massachusetts uses leasing agreements for computers, phones, and internet services, both for direct and contracted staff. The administrative budget assumes $300/ desktop computer annually and $250 for VOIP (Voice Over Internet Protocol) annually, for each of the 15 direct and contracted MFP FTEs. The commonwealth also built in $350 for 2 laptop computers that would be used to administer the MFP Quality of Life Surveys.

Other costs

Administrative Transition Activities. Massachusetts plans to contract for certain administrative activities to facilitate potential MFP participants' transition from qualified facility settings to qualified residences in the community. We expect that contractors will need the ability to fund certain activities to fund transition preparations in the 180 days prior to transition. Some examples of these activities include taking an individual to see potential housing options

and skills training. Massachusetts budgeted $4,000 per MFP participant for this resource to be available to transition coordinators and MFP participants.

Massachusetts also assumed that some attempted MFP transitions would not result in a successful transition. The administrative budget includes $4,000 per unsuccessful transition, and assumes that the number of unsuccessful transitions would equal 15% of the successful transitions. The commonwealth requests that CMS match these expenditures at the 50% FMAP rate.

Training. Massachusetts assumed that the five (5) Contracted Regional Housing Coordinators would require initial training during their first year. The commonwealth budgeted $20,000 in training costs for this group; half to occur at the beginning of the contract in August and September 2011, and the other half to occur between October 2011 and March 2012.

Massachusetts also assumed that state staff, including MFP staff, and providers would need periodic training on the MFP program and how it should be changing members' interactions with various aspects of the Medicaid program. The administrative budget includes $200,000 annually for all other training needs related to MFP.

Outreach Activities and Materials. The commonwealth expects to produce various materials and conduct outreach activities related to the implementation and ongoing operation of the MFP Demonstration. The administrative budget includes $250,000 in initial costs for design and production to be expended through December 2011, and $250,000 annually for ongoing outreach activities and materials for new MFP participants.

Quality of Life Surveys. The commonwealth expects to spend $100/per survey to conduct the required MFP Quality of Life Surveys (to be conducted 1 month prior to transition, 11

months in the community, 24 months in the community). The administrative budget also assumes that 5% of the surveys may need to be repeated (such as if a planned transition from a facility is delayed for several months). The commonwealth understands that CMS will reimburse participating MFP states $100 each for each survey conducted.

Administrative Costs of Existing HCBWs. The commonwealth anticipates that many MFP participants will transition from facility settings into one of Massachusetts' existing Home and Community-Based Waivers. For these individuals, the commonwealth requests reimbursement for the portion of HCBW administrative costs (this does *not* include an allocation of administrative case management costs) associated with the MFP participants in their 365 post-transition period. In the administrative budget, the commonwealth has included an estimated per member per year (PMPY) amount and calculated the administrative cost associated with projected MFP participants each year. The PMPY ranges by waiver from $812 to $1,776.

Administrative Case Management for New MFP HCBWs. The commonwealth expects to provide administrative case management for MFP participants transitioning into the two planned MFP Transition HCBWs. The administrative budget includes an estimate of the cost of administrative case management associated with MFP participants in their 365 post-transition period. The cost of administrative case management is calculated based on a draft rate for administrative case management developed by the Massachusetts Division of Health Care Finance and Policy. The costs components are $195 per member per month starting in July 2012 multiplied by the average projected length of stay (10.8 months) for each MFP participant in their 365 post-transition period. The commonwealth requests that CMS match these expenditures at the 50% FMAP rate.

Information Technology and Data Resource Requirements. The commonwealth projects that it must make several *significant* investments in information technology in order to identify and track information about MFP participants, to manage care planning information for MFP participants during and post-transition, to match MFP participants with accessible housing and self-directed Personal Care Attendants, and to comply with the MFP data and reporting requirements. The commonwealth requests that CMS match these expenditures at the 100% FMAP rate.

MA-21. The administrative budget includes $116,050 in initial costs for system changes to be expended through June 2011, and $69,000 annually for operations beginning in July 2011. Ongoing operations costs were estimated by sampling the number of annual transactions required for a similar population to the anticipated MFP population, and extrapolating the cost of those transactions.

MMIS. The administrative budget includes $597,448 in initial costs for system changes to be expended through December 2011, and $75,000 annually for operations beginning in July 2011. Ongoing operations costs were estimated by sampling the number of annual transactions required for a similar population to the anticipated MFP population, and extrapolating the cost of those transactions.

Data Warehouse. The administrative budget includes $143,750 in initial costs for system changes to be expended through December 2011, and $35,938 annually for operations beginning in July 2011. Ongoing operations costs were estimated at 25% of the initial system change costs.

Virtual Gateway Application. The commonwealth proposes building an interface for Transition Coordinators and others facilitating transitions to identify potential MFP Participants so that the commonwealth may track them through to successful transition and enrollment in the

MFP Demonstration. The Virtual Gateway provides an interface for providers and outreach workers today. The administrative budget includes $250,000 in initial costs for system changes to be expended through December 2011, and $75,000 annually for operations beginning in July 2011. Ongoing operations costs were estimated at 30% of the initial system change costs.

Care Planning Application. The commonwealth proposes building a system or modifying an existing system to allow for care planning management for MFP Participants for whom the commonwealth does not currently have such a system. The administrative budget includes $800,000 in initial costs for a new system or system changes to be expended through December 2011, and $80,000 annually for operations beginning in July 2011. Ongoing operations costs were estimated at 10% of the initial system change costs.

MassAccess Housing Registry. The administrative budget includes $20,000 in system changes to be expended through December 2011, and $80,000 annually for operations beginning in July 2011. Ongoing operations costs are based on recent historical costs of operating this system. The MassAccess Housing Registry is not expected to have a state funding source in SFY2012 or going forward and would be retired if not for MFP funding.

MDS 3.0 Section Q Data. The administrative budget includes $100,000 to be expended through December 2011 to integrate this data into MassHealth's Data Warehouse. It also includes, and $25,000 annually for operations beginning in July 2011. Ongoing operations costs were estimated at 25% of the initial system change costs.

Massachusetts Aging and Disability Information Locator (MADIL). The administrative budget includes $0 in initial costs for system changes to be expended through December 2011, and $175,000 annually for operations beginning in July 2011. Ongoing operations costs are based on recent historical costs of operating this system. MADIL is not expected to have a state

funding source in SFY2012 or going forward and would be retired if not for MFP funding. It is a critical resource for information for MFP participants and other disabled and elder individuals.

Personal Care Attendant (PCA) Registry. The PCA Registry would connect MFP Participants with potential Personal Care Attendants. The administrative budget includes $100,000 in initial costs for system design and building to be expended through December 2011, and $25,000 annually for operations beginning in July 2011.

Senior Information Management System (SIMS). The SIMS system is used to manage case management, service planning, billing, and assessments information for participants in the commonwealth's Frail Elder Waiver. The administrative budget includes $70,000 in initial costs for system changes to support tracking for MFP to be expended through December 2011, and $20,000 annually for operations beginning in July 2011. Ongoing operations costs were estimated at 25% of the initial system change costs.

The commonwealth is requesting $6,832,410 in administrative costs be reimbursed at the 100% rate in CY2011. The commonwealth is not proposing a State Evaluation program for MFP, so no costs are included for this purpose.

Budget projections (Demonstration Services and Qualified HCBS) for all MFP populations are based on data used to generate the commonwealth's CMS-372 reports for similar Home and Community Based Waiver participant populations, historical expenditure data from the SCO and PACE programs, and encounter data from managed care programs for diversionary behavioral health services offered under the commonwealth's 1115 Demonstration. The commonwealth anticipates beginning MFP transitions in July 2011, although administrative

costs are expected to begin in the first quarter of CY2011 in anticipation of the proposed July 2011 transition start date.

The calculated per capita costs for each of the transition populations can be found in the chart below. The average per capita cost for all demonstration participants (aggregate) is included on the bottom line of the chart. Note that these cost estimates only include MFP spending, and not spending for other Medicaid or state-funded cost components, such as primary care, or the cost of room and board for those participants using a residential habilitation service.

Projected Per Capita Costs for MFP Transition Populations	**CY 2011**	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**	**CY 2016**
Elderly	$65,420	$65,700	$165,718	$189,998	$194,834	$200,713
MR/DD	$131,691	$145,372	$446,568	0	0	0
Physically Disabled	$111,585	$104,083	$238,473	$294,694	$301,653	$310,447
Mental Illness	$72,857	$155,855	$415,164	$446,085	$456,219	$469,156
Average Aggregate	$88,241	$93,313	$233,448	$273,637	$280,196	$288,371